DEPT.- 65

JOB- 21

REEL- 42

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

VP 23007

CITY HALL

BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN--PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type--(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber, M.D. Title: Commissioner of Health — Date: 3/28/63

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS: 2 negative Rolls

C P Force — Records Management Officer — Date: 3/28/63

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KP 23907

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Horney Attorney

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57256

D 57256

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH City Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST.: 8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Horney

(a) RESIDENCE. NO. Bay View ST., WARD.

Olivia and Washington sts.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 10 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel A Horney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary A Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Hosp. Records (Address)

15 Filed SEP 22 1921 19 L. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25 - 1921

17

I HEREBY CERTIFY, That I attended deceased from 8-23 - 1921, to 9-25 - 1921

that I last saw him alive on 9-25 - 1921

and that death occurred, on the date stated above, at 6 P M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Mitchell M. D.

19 (Address) City Hosp. Bayview

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 9/29/21

20 UNDERTAKER: H E Hughes — ADDRESS: 847 N Broadway

N. B.—Answers to questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1234 W. 38th St. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth E. Gray.

(Residence in Baltimore: No. 1234 W. 38th St 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	White	single

6-DATE OF BIRTH, Mar 6, 1843
(Month) (Day) (Year)

7-AGE, 77 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John D Gray

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Jenkins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Agnes Handley

(Address) 1231 W 38th St

15-

Filed SEP 27 1921, 191

I. E. Weir Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Sept 26, 1921 (Address) 1522 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Marys Cem. Govans	Sept. 28, 1921
20-UNDERTAKER	ADDRESS
Wm Cook & Son	502 E. Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57258 HEALTH DEPARTMENT—CITY OF BALTIMORE (V) D 57258

CERTIFICATE OF DEATH. (Typewrite)

1-PLACE OF DEATH — REGISTERED NO. C 64

CITY OF BALTIMORE: (No. Baltimore Hospital St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Howard Snodgrass

(Residence in Baltimore: No. 616 Franklin Road St.; ....yrs., ...mos. ....ds.)

or 2805 W Lanvale "

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ...Mar.... (Month) ....2.... (Day), 1860 (Year)

7-AGE, 61 yrs. 10 mos. ....ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....Act....
(b) General nature of industry, business, or establishment in which employed (or employer) ....Stone....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ruth B Becker

(Address) 2805 W Lanvale St

15-

Filed SEP 27 1921, 191.... J. E. WOHLT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 26th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1921, to Sept 26 1921, that I saw h[illegible] alive on Sept 26 1921, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas B Nattin M. D.

Sept 26, 1921 (Address) 312 W Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....dr. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Westminster | DATE OF BURIAL, Sept 28 1921

20-UNDERTAKER Wm Lackman & Nat'l Co | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Lipscomb

D 57259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1814 Mullin St. 15 79 WARD) Registered No. C.

2-FULL NAME Mary Lipscomb

(Residence in Baltimore: No. 1814 Mullin St.; 34 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female | 4-COLOR OR RACE, colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, October 4, 1887
(Month) (Day) (Year)

7-AGE, 34 yrs. 11 mos. 20 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Thos Scott

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Ida Bell

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Scott

(Address) 1814 Mullin St

15-

Filed ....., 191.... Registrar.

SEP 27 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 24, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) endocarditis

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept 24 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, Sept 27 1921

20-UNDERTAKER Edw Ruggold | ADDRESS 1437 N Carey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57260

CERTIFICATE OF DEATH.

29 ✓ D 57260

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. PHS Hosp. #56/

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 24 WARD)

2-FULL NAME Charles Brown

(a) RESIDENCE NO. US. PHS Hosp. #56 Balto., Md ST., 30 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Charless Brown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... ---- 040

(c) Name of employer ------

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Balto. Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1921 to Sept; 25, 1921.
that I last saw h imalive on Sept. 25, 1921
and that death occurred, on the date stated above, at 10'20 A. M.
The CAUSE OF DEATH* was as follows:

Tuberculosis acute miliary

July 12,/21 (duration) -- yrs. --- mos da.

CONTRIBUTORY (Secondary) ---

-- (duration) -- yrs. -- mos. ---- da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) J D Rencland M. D.

9/25/1921 (Address) P.A. Surgeon US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 28 21
20 UNDERTAKER	ADDRESS
Edw Ramsgold	1463 Cary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 57261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57261

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Ashburton ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Schaefer

(a) RESIDENCE No. 1702 Ashburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mathilda Schaefer

(Address) 1702 Ashburton Ave

15 Filed SEP 27 1921 I. E. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to Sept 25, 1921,

that I last saw her alive on Sept 26, 1921,

and that death occurred, on the date stated above, at 12-30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Chronic Nephritis

(duration) about 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Paralysis, Apoplexy

(duration) yrs. mos. 16 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter E Twickman, M. D.

Sept 26, 1921 (Address) 2002 N Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 27, 1921
20 UNDERTAKER Wm. J. Tickner	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 57262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57262

109

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roman Harris

(a) RESIDENCE. NO. 2321 Mendawin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lottie Harris

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 045
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Husband
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis
(Address) 1411 Eutaw St

15 Filed SEP 27 1921, 19 L. E. Wohl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1921, to Sept 26, 1921, that I last saw him alive on Sept 26, 1921, and that death occurred, on the date stated above, at 6.25 p.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia 9/20/21
(duratiun) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/20/21

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M.D. Douglas, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehren Washington Rd — DATE OF BURIAL: 9/27 1921

20 UNDERTAKER: Jack Levis — ADDRESS: 1411 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Warnick

HEALTH DEPARTMENT—CITY OF BALTIMORE

57263 57263

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 669 W. Fayette ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Warnick

(Residence in Baltimore: No. 669 W. Fayette St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, July 27, 1821 (Month) (Day) (Year)

7-AGE, 50 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Richard Warnick

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md.

12-MAIDEN NAME OF MOTHER Melvina McKean

13-BIRTHPLACE OF MOTHER (State or Country), Balt. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Melvina McKean
(Address) 511 N. Fulton Ave

15-
Filed SEP 2 1921
Filed M. J. A., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1921, to Sept 26 1921, that I saw h[illegible] alive on Sept 26 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 2 mos. ds.

(Signed) Henry H. Wantzen M. D.

Sept 27, 1921 (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Co. DATE OF BURIAL, Sept 29, 1921.

20-UNDERTAKER Joseph B. Cook ADDRESS No. 3 N. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57264

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Moore

(a) RESIDENCE. No. 257 Hamburg st. (E.) ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not recorded

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Wm. Henry Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Ann Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed SEP 26 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1921, to Sept. 24, 1921, that I last saw him alive on Sept. 24, 1921, and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. Sputum, X-ray

(Signed) Frances L. Badaglucco, M. D.

9-24-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 29 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Baltimore St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57265

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1259. E. North Ave ST.: 9 WARD)

2-FULL NAME Annie A. Hagan.

(a) RESIDENCE No. 1259. E. North Ave ST.. WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 24 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: S. Hagan.

6 DATE OF BIRTH (month, day, and year): Dec 9. 80

7 AGE: Years 41 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Richard O. Toole.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Catherine Murray.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Richard Hagan. 1259. E. North Ave

15 Filed: Sept 27 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921, to Sept 26, 1921, that I last saw her alive on Sept 23, 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. E. Lowenbach, M. D.

9-27 1921 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Sept. 29 1921

20 UNDERTAKER: George F. Ruth

ADDRESS: 1735 Hanford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. New City Hospital, Bay View ST.; 23 WARD)

2-FULL NAME John W. Phillips

(a) RESIDENCE. No. 61 E. Randall St ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 64 yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed SEP 27 1921 I. E. Wehal Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1921, to Sept. 26, 1921, that I last saw him alive on Sept 26, 1921, and that death occurred, on the date stated above, at 8:25 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Tabes Dorsalis (Syphilitic)

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 10 yrs

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde M. Reid, M. D.

9/26/ 21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Oakland Church Md.	Sept. 28/21
20 UNDERTAKER	ADDRESS
George L. Schwab & Bro.	2101 Fredk. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57267

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 S. Curley ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha M. Murphy.

(a) RESIDENCE NO. 715 S. Curley. ST., 1 WARD 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22 - 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attended school.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Murphy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Rosanna Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Henry Murphy. (Address) 715 S. Curley St.

15 Filed ..... 19 Robert F. Harrison, Registrar
Burial ~~Permit~~ Clerk.

P 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Sept 26, 1921, that I last saw her alive on Sept 26, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. D. McAvoy, M. D.

9/27, 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Sept 28 1921
20 UNDERTAKER Tully & Jenkins	ADDRESS [illegible]

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 57268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57268

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 347 E. Pratt St. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Brown

(a) RESIDENCE NO. 3417 E. Pratt St. ST., 76 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Brown

6 DATE OF BIRTH (month, day, and year) Nov. 17-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper. 086

(b) General nature of industry, business, or establishment in which employed (or employer) Turnin-Whitty-Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark.

12 MAIDEN NAME OF MOTHER Magdalene Nordman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Margaret Brown

(Address) 3417 E. Pratt St.

15 Filed ..... 19 .....

Registrar

P 27 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 23/21 to Sept 25 1921, that I last saw him alive on Sept 25 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no. Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Norman M. D.

9/27/21 (Address) 1919 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Sept 28 1921

20 UNDERTAKER Lilly & Feile ADDRESS 403 N. Gay St.

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See Instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57269

CERTIFICATE OF DEATH.

D 57269

1-PLACE OF DEATH Church Home + Infirmary

CITY OF BALTIMORE: (No. 126 N. Broadway ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edward M. Jarbutton

(a) RESIDENCE. NO. 816 N. Payson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie D. Jarbutton

6 DATE OF BIRTH (month, day, and year): 12/20/1883

7 AGE: Years 37 Months 8 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Balt. Police Dept

9 BIRTHPLACE (city or town) (State or country): Queen Ann Co. Maryland

PARENTS

10 NAME OF FATHER: George H. Jarbutton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co. Maryland

12 MAIDEN NAME OF MOTHER: Ardell Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Maryland

14 Informant: George M. Jarbutton

(Address) 4608 Harford Rd.

15 Filed ~~Dec.~~ 19.. Robert F. Harrison Registrar

SEP 27 1921 E. Jarbutton

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1921, to Sept. 26, 1921, that I last saw h~~im~~ alive on Sept. 26, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Tonsilitis

Adenoids

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute bronchitis 1 week

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 26 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. D. Noble M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stevensville Cemetery Kent Island

DATE OF BURIAL: Sept. 29 1921

20 UNDERTAKER: George J. Smith

ADDRESS: 1000 N. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—100 Bks.

D 57270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57270

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) University Hospital ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. A. Shawacre

(a) RESIDENCE. No. 619 Dennison st ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Shawacre

6 DATE OF BIRTH (month, day, and year): June 24/1872

7 AGE: Years 49 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer): Industrial

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Geo. W. Shawacre

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant: University Hospital Address: Broadway & Fayette Baltimore

15 Filed 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1921, to Sept. 27, 1921, that I last saw him alive on Sept. 27, 1921, and that death occurred, on the date stated above, at 7.35 a. m.

The CAUSE OF DEATH* was as follows:

General peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute perforative appen-dicitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Sept. 23, '21.

Was there an autopsy? No.

What test confirmed diagnosis? Findings at operation

(Signed) W B Jopson, M. D.

Sept 27 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 29 '21

20 UNDERTAKER: George H. Smith ADDRESS: 1007 W. Fayette St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

27 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57271

CERTIFICATE OF DEATH.

REGISTERED No. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pierce

(a) RESIDENCE. No. 654 Cider Alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jim Baily

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Harriett Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M. C. H.

15 Filed SEP 27 1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1921, to Sept. 22, 1921, that I last saw her alive on Sept. 22, 1921, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in Sputum X-ray

(Signed) Frances L. Dalaglacca M. D.

9-23-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND. SEP 27 1921

20 UNDERTAKER Commissioner Health, per Wm. F. WOODALL

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57272 D 57272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 Cumberland St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Crairley

(a) RESIDENCE No. 705 Cumberland St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifes yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45 ?			

8 OCCUPATION OF DECEASED 041

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Day work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Perry Albert

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Jarlia Brady

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant William Washington (Address) 705 Cumberland St.

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

P 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Sept 26, 1921, that I last saw h[illegible] alive on Sept 25, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

9/27, 1921 (Address) 1928 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	9/28 1921
20 UNDERTAKER	ADDRESS
Geo. H. Hooper & Co.	40 W. Conway St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57273

91-089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 N Dunbar ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Watts

(a) RESIDENCE. NO. 1606 N Dunbar ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Watts

6 DATE OF BIRTH (month, day, and year) March 14 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bed weaver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore Spring Co

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Robert Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucinda Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mary Watts
(Address) 1606 N Dunbar St

15 Filed 19 Robert F. Harrison, Registrar

SEP 27 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-22, 1921, to 9-25, 1921, that I last saw h[illegible] alive on 9-25, 1921, and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) T. T. Burt Co, M. D.

9-27, 1921 (Address) 703 N Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Sept 29 1921
20 UNDERTAKER	ADDRESS
Jas L. Miller	2334 Jefferson St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state more CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57274

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Harris

(a) RESIDENCE. No. 446 N. Orchard St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed Sept 28 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1921

17 I HEREBY CERTIFY, That I attended deceased from September 7, 1921, to Sept 25, 1921, that I last saw him alive on Sept. 25, 1921, and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 9-16-1921

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) L. L. Brady M. D.

9/26/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL — Sept 28, 1921

20 UNDERTAKER — ADDRESS — Saml L. Hender 598 Mad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57275 HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 57275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 590 N. Bidd St. 17 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emanuel Hawkins

(Residence in Baltimore: No. 906 Pear alley St.; 77 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	Married

6-DATE OF BIRTH, ... March (Month) ..... (Day), 1864 (Year)

7-AGE, 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Hawkins

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Kitty Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Tolliver

(Address) 906 Pear alley

15-

Filed ....., 191.....

Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 24 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Hennessy M. D. (Coroner.)

Sept. 27, 1921 (Address) 202 Eutaw st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National	Sept. 28, 1921
20-UNDERTAKER	ADDRESS
Samuel Hemsley	500 Bidd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 27 1921

(Boston)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57276

CERTIFICATE OF DEATH.

X 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Boston

(a) RESIDENCE. NO. Ivy Neck, Cumberstone Md ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~Lyrs.~~ 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Daniel Boston

6 DATE OF BIRTH (month, day, and year) Jan 5, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Victor Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daniel Boston

(Address) Ivy Neck Cumberland Md

15 Filed SEP 27 1921 Robert F. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Sept 25, 1921.

that I last saw h[illegible] alive on Sept 25, 1921,

and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Obstruction of Cardiac ~~and~~ of Stomach.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Asthenia.

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Aug 15, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms, Surg.

(Signed) John A. Foss, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakeville, West Lawn	Sept 27 1921
20 UNDERTAKER Sam Hensley	ADDRESS Braddock

MANNER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 170 D 57277

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Thomas Fillmany

(Residence in Baltimore: No. Monkton Md.

St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work, Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, L. Fillmann

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Fillmann

(Address) Monkton Md

15-

Filed ....., 191.....

Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Coroner, on~~ ~~(Inquest, autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound in abdomen
Caused by accidental discharge of gun
24 hrs
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident
(Duration) ..... yrs. ..... mos. 24 hr ds.

(Signed) H. K. Gorsuch M. D.
(Coroner.)

9/28 ....., 191.. (Address) 117 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Monkton Md.

19-PLACE OF BURIAL, OR REMOVAL, St James Balto Co — DATE OF BURIAL, Sept 29 1912

20-UNDERTAKER F. C. Brooks — ADDRESS Spark Md

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Maciolek)

Spec.—8-24-14—M. & T.—2000 Blks.

D 57278

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 57278

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~84~~ 815 S Grove St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Maciolek

(Residence in Baltimore: No. 815 S. Grove St St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) 9 (Day), 1920 (Year)

7-AGE, 1 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Maciolek

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Ziarko

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Maciolek

(Address) 815 S Grove St

15-

Filed SEP 28 1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 26 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 26 1921, that I saw h.. alive on Sept 26 1921, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ....yrs. about 10 da

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank Bijanowski M. D.

Sept 28, 1921. (Address) 245 Penn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem

DATE OF BURIAL, Sept 28, 1921

20-UNDERTAKER Stephen J Kralkowski

ADDRESS 1000 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 57279

150538.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 ✓ D 57279

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

2-FULL NAME Antonio Santos.

(a) RESIDENCE NO. 530 N. Colvin St. City ST.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. dy. WARD .....

How long in U. S., if of foreign birth? Unknown mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida (wife).

6 DATE OF BIRTH (month, day, and year) March 2, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	38	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) lie in Balt 20 years Portugal

PARENTS

10 NAME OF FATHER Julio Santos.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portugal

12 MAIDEN NAME OF MOTHER Amelia Ferrard.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portugal

14 Informant (Address) Johns Hopkins Hospital Records.

15 SEP 28 1921 Filed ....., 19 ..... M. A. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1921, to Sept 25, 1921.

that I last saw him alive on Sept 25, 1921.

and that death occurred, on the date stated above, at 3 16 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic aortitis. aortic & Mitral Insufficiency. Myocardial Insuff.

(duration) X yrs. 2 mos ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H B Herman ..... M. D.

9-26, 1921. (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int—Aurlow Cem	Sept 28 1921
20 UNDERTAKER	ADDRESS
Wm A Robert-A Elliott	1725-Ashland Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57280 — 170 D 57280

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1036 Leadenhall St.: 73 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Owens

(a) RESIDENCE No. 1036 Leadenhall St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Owens

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 60	?	?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General natore of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Sarah Perry
(Address) 1036 Leadenhall St

15 Filed ..., 19... M.T.O. Registrar

SEP 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6th, 1921, to Sept 26, 1921, that I last saw h[illegible] alive on Sept 26, 1921, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Postal yrs. mos. ds.

CONTRIBUTORY (Secondary) Condiloma Vaculan

Insufficiency (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) D. Harrell, M. D.

9/27, 1921 (Address) 1400 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	Sept 28 1921
20 UNDERTAKER	ADDRESS
S. H. Brown's Son	1018 W. Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57281

D-57281

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 605 Archer ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha C. Johnson,

(a) RESIDENCE. NO. 605 Archer ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw. Johnson.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60.		?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) (37)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edw Johnson (Address) 605 Archer St

15 Filed SEP 28 1921, 19.... W. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 22nd, 1921, to Sept 26th, 1921, that I last saw h-e alive on Sept 26, 1921, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. H. Carroll M. D.

, 19 (Address) 1701 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Sept 28 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 W. Hill St

mation should be carefully supplied. Age, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement as TION is very important. See instructions on back of certificates.

57282

HEALTH DEPARTMENT—CITY OF BALTIMORE

57282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. P. S. Hosp. No. 172

CITY OF BALTIMORE (No. Md. Gen. Hosp. St. 14 WARD) REGISTERED No. C

2-FULL NAME Kathryn A. Biddison

(Residence in Baltimore: No. 520 N. Stricker St. St.: 74 yrs., 5 mos. 28 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, March 28, 1847 (Month) (Day) (Year)

7-AGE, 74 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none HD
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Maysback Beddison

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Cathyn Deal

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie C. Crambitt

(Address) 520 N. Stricker St.

15- Filed SEP 28 1921 L. E. Wehn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Fell down stairs

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Sept 27 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place ~~not known~~ Hosp. in the of death U. P. S. mos. 4 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? Whitelocks Boarding House

Former or usual residence 520 N. Stricker St.

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem't DATE OF BURIAL, Sept 25 1921

20-UNDERTAKER William Carl ADDRESS 502 E Madison

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57283

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Guilford Ave Bon Ball Hospital ST. OR WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George Bender

(Residence in Baltimore: No. 2525 Jones St. Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Wht

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: August 2, 1891 (Month) (Day) (Year)

7-AGE: 30 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Harry Bender

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Alice Creecy

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Bender

(Address) 2407 Hasle Road

15-

Filed SEP 28 1921 191 L. E. Webb Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanide Poisoning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Arthur J. Walker M. D. (Coroner)

9-26, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park DATE OF BURIAL, Sept 28, 1921

20-UNDERTAKER: William Cook ADDRESS 542 E Mulberry

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57284 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1703 Thomas Ave ST.: 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Johnston

(Residence in Baltimore: No. 1703 Thomas Ave St.: 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, August 22, 1848 (Month) (Day) (Year)

7-AGE, 73 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work machinist
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Missouri

PARENTS.

10-NAME OF FATHER, ~~William Hilbert~~ Geo. Johnston

11-BIRTHPLACE OF FATHER (State or Country), Missouri

12-MAIDEN NAME OF MOTHER ~~George Johnston~~ Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary C. Johnston

(Address) 1703 Thomas Ave.

15- SEP 28 1921

Filed ....., 191.... I. E. Wahl Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 27, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) no history (Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Sept. 27, 1921 (Address) 2802 E. Fayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemy DATE OF BURIAL, Sept 29. 1921

20-UNDERTAKER Jos Forsters Son ADDRESS 217 S. Broa...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T—1500 Blks.

150816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57285

CERTIFICATE OF DEATH.

X 45 ✓ D 57285

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST., ? WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie A. Wicke

(a) RESIDENCE NO. 1217 Anne St. Portsmouth, Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or WIFE of) Charles Wright (Brother) 1216 E. Capitol St. N.E. Wash. D.C.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Music Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): — 186

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: —

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant (Address): Johns Hopkins Hospital Records.

15 Filed SEP 28 1921, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1921, to Sept 26, 1921, that I last saw her alive on Sept 26, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Endothelioma)

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept 16 '21

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

9.26.21, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Staunton Va

DATE OF BURIAL: 9/28 19 21

20 UNDERTAKER: Josh Lewis 1411 E. Balto St

ADDRESS

IMPORTANT: Information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 57286

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Rear of 1230 W. Cross ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Maloney

(Residence in Baltimore: No. 1015 W. Cross St. St.; yrs. 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ? (Month) ? (Day) 1866 (Year)

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sup't of Store
(b) General nature of industry, business, or establishment in which employed (or employer): Room at City Hall

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Maloney

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Catherine Roach

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary V. Dolan

(Address) 1015 W. Cross St.

15- SEP 28 1921 191 [signature] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic tuberculosis of lungs

Absent / (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James McKenna M. D. (Coroner.)

Sept 27 1921 (Address) 705 E Chase St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Cathedral Cem	Sept 29" 1921
20-UNDERTAKER	ADDRESS
Joseph B Cook	1003 N Ballo St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 57287

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 435 N. Gilmor St. ST. 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Lacy

(Residence in Baltimore: No. 435 N. Gilmor St.; yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	Single

6-DATE OF BIRTH, Sept. 20, 1921
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 5 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none 000
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Herbert Tate

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Hattie Lacy

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Lacy

(Address) 435 N. Gilmor St.

15-

Filed SEP 26 1921, 191.... M. A. .....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Fracture skull

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept 26 1921 (Address) 2802 Edgewood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn	Sept 28 1921

20-UNDERTAKER Wm. H. Fogle & Son ADDRESS 1400 Mosher

AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57288 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

28 D 57288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 771 George St.: 17 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Collett

(a) RESIDENCE. No. 771 George St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nannie Collett

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 41 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wagon Driver

(b) General nature of industry, business, or establishment in which employed (or employer): — 023

(c) Name of employer: Mothw + Co.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Daniel Easton
(Address): 916 Penna ave

15 Filed SEP 28 1921, 19 L. E. Wohlt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3. 1921. to Sept. 27. 1921. that I last saw her alive on Sept. 27. 1921. and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Entarcabosis

(duration) uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam. Sputa

(Signed) Frank Ellegood M. D.

Sept. 28. 1921 (Address) 1006 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Sept 29 21

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Pa. ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57289

CERTIFICATE OF DEATH.

104-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Ridgely St.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Thompson

(a) RESIDENCE. NO. 1107 Ridgely ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Fred. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Harriet Ridgely

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant: Mr. Frederick Thompson
(Address) 1107 Ridgely St

15 Filed SEP 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to Sept 27, 1921, that I last saw h[illegible] alive on Sept 27, 1921, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchus Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen D. Davis, M. D.

19 (Address) 1 W. Columbus St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept 29, 1921

20 UNDERTAKER	ADDRESS
James Dignan & Son	[illegible] St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 57290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 57290

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2924 Winchester ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Purdum

(a) RESIDENCE. No. 2924 Winchester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha Purdum

6 DATE OF BIRTH (month, day, and year) Aug 26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Josiah W Purdum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Beall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Martha Purdum 2924 Winchester St

15 Filed SEP 28 1921 19 M7a Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to Sept 27th, 1921, that I last saw him alive on Sept 27th, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs 3 mos. ds.

CONTRIBUTORY (Secondary) Assistant Vomiting due to Obstruction (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. C. Small, M. D.

. 19 (Address) 904 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Airy Md	Sept 29 1921
20 UNDERTAKER W M Routson	ADDRESS 2251 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57291

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST. 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Bradyhouse

(Residence in Baltimore: No. 1024 N. Fulton Ave. St.; 35 yrs., mos. ds.)

AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is ... Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) single

6-DATE OF BIRTH, Jan. 20, 1877 (Month) (Day) (Year)

7-AGE, 44 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Tile worker)
(b) General nature of industry, business, or establishment in which employed (or employer) (Helper)

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Thos. Bradyhouse

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Matilda Dunn

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lydia Bradyhouse

(Address) 1024 N. Fulton Ave.

15-

Filed ....., 191.....

Robert F. Harrison,

Burial Permit Clerk. Registrar.

SEP 28 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Automobile accident

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Sept. 28, 1921 (Address) 2807 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. In the of death ....yrs. ....mos. 1 ds. State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Riddle & Gregg Sts.

Former or usual residence 1024 N. Fulton Ave.

19-PLACE OF BURIAL, OR REMOVAL, Fremont Cem. DATE OF BURIAL, 9/29, 1921

20-UNDERTAKER George A. Farley ADDRESS Fulton & Fayette

Spec.—8-24-14—M. & T.—2000 Blks.

(Sadie Mabel)

D 57292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57292

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5302 Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Mabell

(Residence in Baltimore: No. 5302 Bruce St.; whole life ....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, April (Month) 8 (Day), 1882 (Year)

7-AGE, 39 yrs. 5 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private families

9-BIRTHPLACE, (State or Country), Balto. City Md

PARENTS.

10-NAME OF FATHER, John Wm. Hawkins

11-BIRTHPLACE OF FATHER (State or Country), Balto. City Md

12-MAIDEN NAME OF MOTHER Louisa Lomax

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Nada Hamilton

(Address)....5302 Bruce St.

15-

Filed.....Robert F. Harrison,.....
Registrar.

P 28 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1921, to Sept 26 1921, that I saw h[illegible] alive on Sept 26 1921, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthma, sepsis and malignant attack

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic valvular heart disease (Duration) about 1 yr. ....mos. ....ds.

(Signed) Chas. L. M. Gardner M. D.

Sept 28, 1921 (Address) 906 N. Winchester

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Sept 28 1921
20-UNDERTAKER	ADDRESS
Bronn & Freeland & Schroeder	114 S.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Epsc—6-9-13—H. P. Co.—1000 Blks.

D 57293

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D 57293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 506 E. Fort Ave. St. 2W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Rebecca Glackin

(a) RESIDENCE. NO. 506 E. Fort Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Norman Glackin

6 DATE OF BIRTH (month, day, and year): Nov. 19, 1901

7 AGE: Years 19 Months 10 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo. Schrupfogle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Margaret Kintlus

13 BIRTHPLACE OF MOTHER (City or Town) (State or country): Baltimore

14 Informant (Address): Norman Glackin 506 E. Fort Ave.

15 Filed 9-28-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to Sept 26, 1921, that I last saw h alive on Sept 26, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Munroe, M. D.

9-28-21 (Address) 5 Fort Avenue E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Sep. 29 1921

20 UNDERTAKER: Margaret E. Flynn ADDRESS: 1432 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57294

CERTIFICATE OF DEATH.

D 57294

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2401 W Lombard St.: 20 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Connaway

(a) RESIDENCE. No. 2401 W Lombard St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos. B. Connaway

6 DATE OF BIRTH (month, day, and year): About 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Winifred Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Winifred Eagan (Address) 2401 W. Lombard St

15 Filed Sept 28 1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1921, to Sept 27, 1921, that I last saw her alive on Sept 27, 1921, and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

. 19 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 30 1921
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57295 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 57295

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1210 St. Paul ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfd J Anderson

(Residence in Baltimore: No. 1210 St Paul

St.) 47 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mad	white	Marr'd

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Asst Frt. Freight
(b) General nature of industry, business, or establishment in which employed (or employer): Agent B.&O.R.R.

9-BIRTHPLACE, (State or Country), Parma

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER (State or Country), Ft Trenton Pa.

12-MAIDEN NAME OF MOTHER J. Harper

13-BIRTHPLACE OF MOTHER (State or Country), Harpers Ferry

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J Marena Anderson

(Address) 1210 St. Paul

15- Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

P 28 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Pulmon. Embolism

..... Accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Riley M. D.
(Coroner)

Sept 27, 1921. (Address) 1637 Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery DATE OF BURIAL, Sept 29 1921

20-UNDERTAKER Chas. G. Black ADDRESS 742 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57296

CERTIFICATE OF DEATH.

D 57296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Schaffer Ave ST.; 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude Edwards

(a) RESIDENCE. No. 4 Schaffer Ave ST., WARD. Ohusa - Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier

(b) General nature of Industry, business, or establishment in which employed (or employer) U.S. Army.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Maryland

PARENTS

10 NAME OF FATHER George Thomas Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Ella May Carback

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant (Address) Ella May Carback 4 Schaffer Ave Hamilton

15 Filed Sep 28 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Sept 28, 1921, that I last saw h. alive on Sept 28, 1921, and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever (duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Bronchitis & Parotid Abscess (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Ur place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal

(Signed) Henry A. Fine M. D.

(Address) 27 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Oct 1 1921

20 UNDERTAKER H. E. Hughes — ADDRESS 1111 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 57297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57297

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. #25 School. Rt Pk & Mt Ederson ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah margolis

(Residence in Baltimore: No. 2401 Ashland ave St.; yrs., 11 mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Jan — (Month), (Day), 1912 (Year)

7-AGE, 8 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Girl
(b) General nature of industry, business, or establishment in which employed (or employer). ---

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Henry Margolis

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Dora Charnof

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Margolis

(Address) 2401 Ashland Ave.

15- SEP 29 1921 191 [signature] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Finley M. D.
(Coroner)
Sept 28, 1921 (Address) 9 E. Cold St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Cemetery — DATE OF BURIAL, Sept 29 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57298 | CERTIFICATE OF DEATH. | 138

D 57298

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N. Bradford ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Bilz

(a) RESIDENCE. No. 109 N. Bradford ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Bilz

6 DATE OF BIRTH (month, day, and year): Jan 5th 1905

7 AGE: Years 16 | Months 8 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Oscar Hunger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Marg. Haesch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. George Boesch

(Address) 109 N. Bradford

15 Filed SEP 2 1921 L. E. Wehr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1921, to Sept 27, 1921, that I last saw her alive on Sept 27, 1921, and that death occurred, on the date stated above, at 9 45 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia. Organic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bright's Kidney Disease

(duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A. A. Hegner M. D.

9/28 1921 (Address) 2600 E. Balt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept. 30 1921
20 UNDERTAKER	ADDRESS
Jos. J. Aderr	156 N. Luzerne Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57299

HEALTH DEPARTMENT—CITY OF BALTIMORE 19✓

D 57299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH.
CITY OF BALTIMORE (No. On way to Mercy Hosp. from Mt Royal & Calvert St. 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Foos.

(Residence in Baltimore: No. 803 41st St. St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), City Balto

PARENTS.

10-NAME OF FATHER, E. Foos

11-BIRTHPLACE OF FATHER (State or Country), City Balto

12-MAIDEN NAME OF MOTHER, Courtney

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Foos

(Address) 803 41

15- SEP 2 1921

Filed ....., 191.... L. E. Wahl
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis ovdv.
Sclerosis aorta & Coronary
Heart Failure (Duration) yrs. mos. ds.
CONTRIBUTORY Cardiac Failure
(Secondary)
Uremia (Duration) yrs. mos. ds.
(Signed) W. S. Riley M. D.
(Coroner.)
Sept 29, 1921 (Address) 1629 Brady

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Com. DATE OF BURIAL, Sept 30, 1921

20-UNDERTAKER J. A. Moran ADDRESS 3000 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–6-9-19–H. P. Co.–1000 Bks.

D 57300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57300

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2700 Springhill Ave ST.; 15 WARD)

2-FULL NAME William Thomas Hamburg

(a) RESIDENCE. No. 2700 Springhill Ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of (or) ~~WIFE of~~ Aurelia Hamburg

6 DATE OF BIRTH (month, day, and year) Jan 5-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	72	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Wheel wright

(c) Name of employer Penna. R. R.

9 BIRTHPLACE (city or town) Metzgerville
(State or country) Wicomico Co. Md.

PARENTS

10 NAME OF FATHER Thos Hamburg

11 BIRTHPLACE OF FATHER (city or town) Wicomico Co. Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Evans

13 BIRTHPLACE OF MOTHER (city or town) Wicomico Co. Md.
(State or country)

14 Informant Mrs. Wm Hamburg
(Address) 2700 Springhill Ave

15 Filed SEP 29 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Sept 28, 1921, that I last saw h~~im~~ alive on Sept 28, 1921, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Paul Brown M. D.

Sept. 29, 1921 (Address) 1837 Penna ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	Oct 1 1921

20 UNDERTAKER Geo. W. Little ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57301

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57301

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) Franklin Square Hospital ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Hartmann

(a) RESIDENCE. NO. 2025 Penrose ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elona Hartmann

6 DATE OF BIRTH (month, day, and year) Oct 13 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Washington D. C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Chas. A. Hartmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Addie Coathill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D. C.

14 Informant Mrs Elona Hartmann

(Address) 2025 Penrose Ave

15 Filed SEP 29 1921 J. P. Wahl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25 . 1921 . to Sept 25 . 1921.

that I last saw him alive on Sept 28 . 1921;

and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis

Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Sept 26. '21

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis M Faintz M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 1 1921

20 UNDERTAKER Geo. Schwab & Bro ADDRESS 2101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57302

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602-412 E. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis V. Poff

(a) RESIDENCE. NO. 602 412 E. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Poff

6 DATE OF BIRTH (month, day, and year): May 1854

7 AGE — Years: 67 Months: 3 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer): 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Poff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

14 Informant (Address): Margaret Poff 602 E. 41st St

Filed SEP 29 19 Mza. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1921, to Sept 27, 1921, that I last saw him alive on Sept 27, 1921, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S Finley, M. D.

9/28, 1921 (Address) 3522 Greenmount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Sept 30 1921

20 UNDERTAKER: Geo. W. Zink & Son, — ADDRESS: 811 W Wolfe

Funeral Directors & Embalmers.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57303 [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE [redacted]

CERTIFICATE OF DEATH.

89D 57303
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 N Paca St. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia C. Smith Dixon

(a) RESIDENCE. No. 122 N Paca ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Chinese

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced BUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 11-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None-900

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Chin Dugon

11 BIRTHPLACE OF FATHER (city or town) (State or country): China

12 MAIDEN NAME OF MOTHER: Lee Shee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): China

14 Informant (Address): Chin Dugon 122 N Paca

15 Filed SEP 29 1921, 19 ... Registrar: L. E. Fahy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1921, to Sept 28, 1921, that I last saw h. alive on Sept 28, 1921, and that death occurred, on the date stated above, at 9-15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Bronchitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): None that I know of

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Young, M. D.

9-29-21 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem. Co.	Sept 29 1921
20 UNDERTAKER	ADDRESS
John Mitchell & Son	W. Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D [redacted] HEALTH DEPARTMENT—CITY OF BALTIMORE D 57304

D 57304

CERTIFICATE OF DEATH.

104 D [redacted]

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 2037 Kennedy Av ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. Stone

(a) RESIDENCE. No. 2037 Kennedy Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. 8 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12-21

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER Lawrence W. Kone

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER Mary E. Busser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Pa.

14 Informant Lawrance W. Kone
(Address) 2037 Kennedy Av

15 Filed SEP 23 1921 19 I. E. White Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27th 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 21 1921, to Sept 27, 1921, that I last saw h on alive on Sept 27 1921, and that death occurred, on the date stated above, at 9 50 P. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Ruhrah, M. D.

Sept 29 1921 (Address) 11 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York. Penna	Sept 30 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2916 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—4-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57305

CERTIFICATE OF DEATH.

H0 D 57305

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 303 Belair Road ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Barsotti

(a) RESIDENCE NO. 303 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of - (or) WIFE of - Mary A. Barsotti

6 DATE OF BIRTH (month, day, and year) Feb. 22. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER not known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs. G. Monfreo. (Address) 303 Belair Road.

15 Filed SEP 29 1921 . 19 M F C Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 . 1921 . to Sept 28 . 1921 . that I last saw h- alive on Sept 28 1921 and that death occurred, on the date stated above, at 12.40 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Tuberculosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Chas Brunck, M. D.

. 19 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer. Cem	9-30 1921
20 UNDERTAKER	ADDRESS
Mrs Chas A J Robide	1200 N Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D 57306
REGISTERED NO.

D 57306
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Berg Harrison White.

(a) RESIDENCE. NO. Taylonia, Lancaster County ST., WARD. Pennsylvania.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Elsie L. White.

6 DATE OF BIRTH (month, day, and year) Sept 12-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~46~~	46	✓	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) near Bay View Maryland

PARENTS

10 NAME OF FATHER Mr. John T. White.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachael Janney.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Elsie L. White (Address) Taylonia Pennsylvania

15 Filed ....., 19.... Registrar

SEP 29 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1921, to Sept. 29, 1921, that I last saw him alive on Sept. 29, 1921, and that death occurred, on the date stated above, at 7:05 a.m.

The CAUSE OF DEATH* was as follows:

Anuria

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Bladder

☆ Pulmonary (duration) 1 yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Cystoscopic examination

(Signed) Robert E. Fricker, M. D.

, 19 (Address) 1418 Eutaw Place, City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Co. Pa	Sept 29 1921
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Sons	N. Y. Pa

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57307

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Left 914 Fayette St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Greenfield

(Residence in Baltimore: No. 914 Fayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Divorced or Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 33 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigarette maker
(b) General nature of industry, business, or establishment in which employed (or employer): 017

9-BIRTHPLACE. (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Greenfield

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Maycoff

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Greenfield

(Address) 914 Fayette St.

15- SEP 29 1921
Filed ....., 191.....
L. E. Wohn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epileptic Convulsions
Epilepsy
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)
Sept 29, 1921 (Address) 1659 Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Friendship Rum — DATE OF BURIAL, Sept 29 1921

20-UNDERTAKER [illegible] — ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57308

CERTIFICATE OF DEATH.

151 D 57308

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 W Saratoga ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Marguerite Eckman

(a) RESIDENCE. No. 2004 W Saratoga ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1			8 hrs. 20 min.

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Henry Eckman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Amelia Nixon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant
(Address)

15 Filed SEP 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22/21 19

17 I HEREBY CERTIFY, That I attended deceased from 9/18/21, 19, to 9/22/21, 19,
that I last saw h[illegible] alive on 9/18/21, 19,
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Levy, M. D.

9/23, 1921 (Address) 810 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 24 19 21
20 UNDERTAKER	ADDRESS
Robt L Brooks for Calhoun	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

I. C. Wehn

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57309

CERTIFICATE OF DEATH.

1920 D 57309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 71 S. Chapel ST., W WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kuniguida Back of.

(a) RESIDENCE NO. 71 S. Chapel St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home 800

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Nicholas Rein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Dufut.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Barbara Backof
(Address) 71 S. Chapel St.

15 Filed SEP 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1921

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to Sept 27, 1921, that I last saw her alive on Sept 26, 1921, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 1 4 11 9

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) Geo Keller, M. D.

9/28 1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Sept 1921

20 UNDERTAKER Lilly & Zirkin ADDRESS 4028 Fr

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79D 57310

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 907 Watson ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Cooper

(a) RESIDENCE. No. 907 Watson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaiah Cooper Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Martha Cooper
(Address) 907 Watson st

15 Filed SEP 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1921, to Sept. 26, 1921, that I last saw h[illegible] alive on Sept. 26, 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl J. Green, M. D.

9-28-1921 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Sept. 30 19 21
20 UNDERTAKER Felix B. Pyr 1028 E.	ADDRESS Mulberry st

CAUSE OF DEATH in plain terms, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57311

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST.: 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wiley.

(a) RESIDENCE. No. 5-11-Exeter St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 25-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	—	—	1 (one)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Oscar Wiley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant H. Cathrall M. D.
(Address) Johns Hopkins Hospital

15 Filed ____, 19 ____ Registrar

SEP 29 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1921, to Sept. 26, 1921, that I last saw h.e. alive on Sept. 26, 1921, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. Cathrall. M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	SEP 2 1921

20 UNDERTAKER (Commissioner Health) per Wm. E. Worrall

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57312

D 57312

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 S. Fremont ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dawton Johnson

(a) RESIDENCE NO. 1019 S. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Thos. Johnson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Francis Tyler

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Francis Tyler
(Address) 1017 S. Fremont Ave

15 Filed SEP 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/14, 1921, to 9/28, 1921, that I last saw h[illegible] alive on Sept 28, 1921, and that death occurred, on the date stated above, at 5:25 P m.

The CAUSE OF DEATH* was as follows:

Acute Toxemia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Endemic Spinal Meningitis (duration) about yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins, M. D.

9/29/21 (Address) 101 9 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 30 1921
20 UNDERTAKER	ADDRESS
Samuel E. Wright	569 Cary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57313 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57313

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Hillman ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Leary

(a) RESIDENCE. No. 1315 Hillman St WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Leary

6 DATE OF BIRTH (month, day, and year) Nov 1, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 640
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Leary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cavanaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Elizabeth Leary, 1315 Hillman St
(Address)

15 Filed Sept 29 1921 Robt T. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 28 1921

17 I HEREBY CERTIFY, That I attended deceased from September 19 1921, to September 28 1921, that I last saw him alive on September 27 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease
(Mitral Stenosis)
(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual Clinical Signs.

(Signed) Henry M. Thomas, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Govans	Oct. 1. 1921
20 UNDERTAKER	ADDRESS
W. C. Windfeld	914 Gruntly

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57314

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 57314

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 Edward St.: 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hans Jackson

(a) RESIDENCE. No. 1227 Edward St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 24, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Howard W. Jackson Sr.

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Kate L. Franklin

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Kate L. Jackson mother
(Address) 1227 Edward St.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28 1921

17

I HEREBY CERTIFY, That I attended deceased from 9/26, 1921, to 9/28, 1921, that I last saw h[illegible] alive on 9/28, 1921, and that death occurred, on the date stated above, at 3.42 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) 2 hours yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) R. J. Gorsuch, M. D.

, 19 (Address) 1416 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Jew. Cem. Balto. Co.	Oct 14 1921
20 UNDERTAKER	ADDRESS
Jas. Jn. Skinner	1625 E. Mad. st

IT IS THE DUTY of the person in charge of the body to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 57315 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57315

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Collins ave. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin.A.Pilling

(a) RESIDENCE NO. 307 Collins ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Pilling.

6 DATE OF BIRTH (month, day, and year) Sep.14.1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77.		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Albert.Pilling

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Jane.E.Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ENgland

14 Informant Mrs.Edith.Pilling. (Address) 307.Collins Ave.

15 Filed 9 29 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1921, to Sept 28, 1921, that I last saw h alive on Sept 28, 1921, and that death occurred, on the date stated above, at 2 60 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) mos ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

9-29 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Roland ave	Sep 30 1921
20 UNDERTAKER	ADDRESS
E. I Fanning & Son	1938 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57316

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Woodland Ave., ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick L. Heiser.

(a) RESIDENCE. No. 7 Woodland Ave., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. II mos. I4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mamie A. Heiser.

6 DATE OF BIRTH (month, day, and year) Oct. I3, I875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	II	I4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett Hayward Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Frederick Heiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda Riddle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mamie A. Heiser.
(Address)

15 Filed SEP 29 1921 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 28, 1921, that I last saw him alive on Sept 27, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate
+ Metastasis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Extraction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Henry D Haban, M. D.

9/29 1921 (Address) 23 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Sept. 30 1921
20 UNDERTAKER	ADDRESS 233 W. Lombard

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57317 ✓ 130 D 57317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) Baltimore Md ST.: 23 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta H. Sauerkoff

(a) RESIDENCE. No. 1932 Hanover St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Sauerkoff

6 DATE OF BIRTH (month, day, and year) June 15 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Rudolph Preis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Wm H. Sauerkoff (Address) 1932 Hanover St

15 Filed Sep 29 1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1921, to Sept. 27, 1921, that I last saw h.. alive on Sept 27, 1921, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Post-Operative Ileus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hysterectomy - One week previous

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No yes Date of Sept 9/19/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles S. Levy, M. D.

Sept 27 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 30 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Endometritis.
Embolism.
Not puerperal.
No further history

D 57318

Jeremiah Daley

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 182 D 57318

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Daley.

(Residence in Baltimore: No. Upper Falls Md St.; yrs., 20 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, July (Month) 1st (Day), 1877 (Year)

7-AGE, 44 yrs. 2 mos. 26 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records St. Joseph's Hospital

(Address)

15-

Filed SEP 30 1921 I. E. Wohn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by person unknown

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) C. Kent Conley M. D. (Coroner.)

9-29, 1921 (Address) 4 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stephens Cemetery

DATE OF BURIAL, Oct 3rd, 1921

20-UNDERTAKER Fred Lassahn & Sons

ADDRESS Baltimore Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57319 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 57319

CERTIFICATE OF DEATH.

152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2546 Eager Place (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angela Ana Baccaro

(a) RESIDENCE. No. 2546 Eager Place St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gabriel Baccaro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Ida Bellarosa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Mr Mrs N S Fonte

(Address) 1830 E Fayette St

15 Filed SEP 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1921, to Sept 28, 1921, that I last saw her alive on Sept 28, 1921, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage
(of the new born.)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. M. Krauss M. D.

. 19 (Address) 3500 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Sept 30 1921
20 UNDERTAKER	ADDRESS
Mr Mrs M S Smith	1535 N Rad[illegible]

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

150845
D 57320

150 D 57320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm E. Crozier Jr

(a) RESIDENCE NO. 12 Singer ave. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14. 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Wm E. Crozier.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rose Edlavitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant James Hopkins Hospital Records
(Address)

15 Filed SEP 3 1921, 19 M.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921, to Sept 29, 1921,

that I last saw him alive on Sept 29, 1921,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of rectum (Stenosis)

(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy.

(Signed) Horace G. Stewart, M. D.

9/30, 1921. (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL Sept 30. 21

20 UNDERTAKER Maf Levinson — ADDRESS 1127 E Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57321

CERTIFICATE OF DEATH.

920 57321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.: 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Meyer Kitt

(Residence in Baltimore: No. 1727 E. Baltimore St.; 15 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, (Month) (Day) (Year) 1866

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Godalia Kitt

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ida

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

15-

Filed SEP 30 1921, 191 M. G. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 27, 1921, to September 30, 1921, that I saw him alive on September 30, 1921, and that death occurred, on the date stated above, at 3.05 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State 15 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1727 E Balto St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel

DATE OF BURIAL, 9/31, 191..

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57322

80 D 57322

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 N. Caroline ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sanuel Mertenbaum

(a) RESIDENCE NO. 717 North Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Karried

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dina Martenbaum

6 DATE OF BIRTH (month, day, and year) -------- 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing 080

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER J.W.Kohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J.Lewis

(Address) 1411 E. Baltimore St.,

15 Filed SEP 3 01921 19 M7.9. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov, 5, 1921 to Sept, 30, 1921.

that I last saw him alive on Sept, 29, 1921,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectonis

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) Davis Franchini M. D.

9/30 1921 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	7 -30 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto. St

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57323

88 D 57323

REGISTERED NO.

1-PLACE OF DEATH St. Josephs Hospital

CITY OF BALTIMORE: (No. ____ St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dixon

(a) RESIDENCE. No. 234 N Population St., — WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black.	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
35-	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) born in Va
(State or country) lived in Balt-20 years

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary Armstrong
(Address) 1436- Madeira St-

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26., 1921, to Sept 28, 1921, that I last saw h er alive on Sept 28, 1921, and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Thyroid Toxemia

6 mos.?

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency 12 Hrs.

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Typical signs + Symptoms

(Signed) Harold C. Pillsbury, M. D.

. 19 (Address) 415 Cedarcroft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: Sept 30 1921

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1725- Ashland Ave

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57324 D 57324

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3223 Fait ave ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Langenfelder

(a) RESIDENCE. No. 3223 Fait ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Geo. H. Langenfelder

6 DATE OF BIRTH (month, day, and year) May 17- 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Richter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Hartman (Sister)
(Address) 820 S. Third St.

15 Filed ..... 19 M. F. G. Registrar

SEP 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to Sept 29, 1921, that I last saw her alive on Sept 29, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. J. McAvoy M. D.

9/29 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Howard's Cemetery	Oct 2 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D 57325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57325

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Jackson & Hyson Sts. ST. 23 WARD) REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Steinbock.

(Residence in Baltimore: No. 13 W. Fort Ave. St.; 63 yrs., 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH. August 13th. 1858, (Month) (Day) 1 (Year)

7-AGE.	If LESS than 1 day,
63 yrs. 1 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Grocery-man.
(b) General nature of industry, business, or establishment in which employed (or employer). 034

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George Steinbock.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Margaret Schmidt.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Steinbock. (brother)

(Address) 13 W. Fort Ave.

15- Filed SEP 29 1921, 191 M74, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 27th. 1921, (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) H. M. Rembaugh M. D. (Coroner.)

Sept. 29..., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk Cem. DATE OF BURIAL, Sept 30 1921

20-UNDERTAKER Mrs. E. Evans & Sons ADDRESS 1428 Charles St

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57326 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 337 E. Hamburg (St.) 24 (Ward) 134

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Kuhn

(a) RESIDENCE. No. 337 E. Hamburg St., 24 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lloyd Kuhn

6 DATE OF BIRTH (month, day, and year): July 12" 1891

7 AGE: Years 30 | Months 2 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md.

PARENTS

10 NAME OF FATHER: Geo. A Hastings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Mollie Pritchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

14 Informant (Address): Lloyd Kuhn 337 E. Hamburg

15 Filed SEP 30 1921 I. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1921, to Sept 29, 1921, that I last saw h alive on Sept 28, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Miscarriage (Cause Natural) 6 ds.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemorrhage 6 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 28

Was there an autopsy? No

What test confirmed diagnosis? Bacteriology

(Signed) R. C. Campbell, M. D.

Sept 29 1921 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md

DATE OF BURIAL: Oct 3 1921

20 UNDERTAKER: Wm J E Evans & Sons

ADDRESS: 1428 N Charles

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57327

HEALTH DEPARTMENT—CITY OF BALTIMORE

57327

CERTIFICATE OF DEATH.

144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bolt Jew Hospital St. 24 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Woelffle

(a) RESIDENCE. No. 1315 Cookie St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret. Woelffle.

6 DATE OF BIRTH (month, day, and year) Sept 9 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer) McEntyre Co

(c) Name of employer Hudson

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER George Woelffle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Magdalina Vogel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Margaret Woelffle 1315 Cookie St

15 Filed SEP 30 1921 19 M.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1921 to Sept 29 1921 that I last saw h.. alive on Sept 29 1921 and that death occurred, on the date stated above, at 8 35 P. m.

The CAUSE OF DEATH* was as follows:

over

Cellulitis (Left Arm)

2 Weeks.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 9/24/21.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James H. Wiehrn M. D.

(Address) Bolt Jew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews Cem.	October 1 1921
20 UNDERTAKER	ADDRESS
Lilly and Zeiler	403 S. Wolfe

TION is very important. See instructions on back of certificates.

ay be properly classified. Exact statement of OCCUPA-

in plain terms, so that it may be

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Only history is that picked pimple on arm which resulted in cellulitis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57328

CERTIFICATE OF DEATH.

64 D 57328

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Selby

(a) RESIDENCE. NO. 1835 McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E Selby

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carrol County, Maryland.

PARENTS

10 NAME OF FATHER Richard Selby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Myra L Leatherwood (Address) 1835 Mc Henry St

15 Filed . 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 19 21.

17 I HEREBY CERTIFY, That I attended deceased from September 18. 19 21. to Sept. 27. 19 21.
that I last saw him alive on Sept. 27. 19 21.
and that death occurred, on the date stated above, at 7.50 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) Louis M. Tonsko M. D.
. 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Sept 30 1921

20 UNDERTAKER: H B Kappel — ADDRESS: 2236 Eutaw Av

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57329

D 57329

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 342 S. Smallwood St. 20 Ward)

2-FULL NAME Wm. Kabrskey

(a) RESIDENCE. No. St. 20 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Asa Faulkner

6 DATE OF BIRTH (month, day, and year): Sept 24-1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Aug Karbosky 342 S Smallwood

15 Filed SEP 30 1921, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 29, 1921.

That I last saw him alive on Sept 28, 1921.

And that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH was as follows:

Chr Interstitial Nephritis

Endocarditis Luetic

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 2 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C. Fetsch M. D.

Sept 30 1921 (Address) 2151 Whitelock

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL 19

20 UNDERTAKER: F. B. Kepfinger & Friedler

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57330 D 57330

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 S. Smallwood St. 20th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Schueller

(a) RESIDENCE. No. 426 S. Smallwood St. 20th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Ernest Schueller

6 DATE OF BIRTH (month, day, and year): Jan 1st 1839

7 AGE: Years 87 Months 8 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Chas Uhl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Fredk Schueller 426 S Smallwood St.

15 Filed . 19 MFA. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1921, to Sept 28, 1921, that I last saw h[illegible] alive on Sept 27, 1921, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix.

(duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Venor A. Condon, M. D.

, 19 (Address) 750 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 30th 1921

20 UNDERTAKER: F. B. Keppert ADDRESS: 2336 Fredk Ave

Instructions on back of certificates. See Instructions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57331

CERTIFICATE OF DEATH.

1082

D 57331

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.: 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Derrick

(a) RESIDENCE NO. 934 Vincent ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ralph Derrick

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Virginia.

PARENTS

10 NAME OF FATHER Jno. Hansen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Virginia

12 MAIDEN NAME OF MOTHER Josephine Mathers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

14 Informant (Address) 18540 UNIVERSITY OF MARYLAND

15 Filed SEP 3 1921 19 Registrar G. H. Cross

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1921, to Sept. 25, 1921, that I last saw her alive on Sept 25, 1921, and that death occurred, on the date stated above, at 7.10 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.
Ruptured Appendix.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at F. S. Hosp.

Did an operation precede death? Yes Date of Sept. 25

Was there an autopsy? no

What test confirmed diagnosis? by Symptoms

(Signed) Louis M. Finch, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19 SEP 29 1921

20 UNDERTAKER (Commissioner Lodge, per. Wm E. Woodall) ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57332

D 57332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Vincent Ave St.) 14 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Reinhardt

(a) RESIDENCE. No. 24 Vincent Ave St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Reinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) 24 Vincent Ave

15 Filed SEP 30 1921 M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30 1921, to Sept 29 1921, that I last saw h[er] alive on Sept 29 1921, and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows: Marasmus (Twin) Cachexia

(duration) yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Leo Holzman M. D.

Sept 29 1921 (Address) 1521 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 1st 1921
20 UNDERTAKER	ADDRESS
Wm C Miller	2334 Jefferson St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57333

D-57333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 104

1-PLACE OF DEATH Robert Garrett Hospital for Children REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Virginia Smith

(a) RESIDENCE. NO. Bowie ST., Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Bowie, Md.

PARENTS

10 NAME OF FATHER George W Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Hinkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant George W. Smith (Address) Bowie Md.

15 Filed SEP 30 1921 19 M. A. C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 29 1921

17 I HEREBY CERTIFY, That I attended deceased from September 20, 1921, to September 29, 1921, that I last saw h[illegible] alive on September 28, 1921, and that death occurred, on the date stated above, at 4.00 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition 000

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Rachitis

(duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ———

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

9-23-1921 (Address) 27 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 1st 1921
20 UNDERTAKER Geo Leisenring & Son	ADDRESS 647 N Broadway

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc, *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc. "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57334

D 57334

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 223 E Fort Ave St. 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. G. Griffin

(a) RESIDENCE. No. 223 E Fort Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 29-1921

7 AGE	Years	Months	Days	If LESS than ~~1 day~~ 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Agnes Kremer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant
(Address) SEP 30 1921

15 Filed . 19 I. E. Wahl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 19 21, to Sept 29, 19 21, that I last saw him alive on Sept 29, 19 21, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Patency Foramen ovale

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Bellotto, M. D.

Sept 30, 19 21 (Address) 1209 Williams Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Sept 30 1921
20 UNDERTAKER	ADDRESS
Margaret S. Flynn	1422 Eight St.

THIS is very important. See instructions on back of certificates. EXACT STATEMENT OF OCCUPA

D 57335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2100 Boone St. WARD) 9

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Zile

(Residence in Baltimore: No. (Parkton md) St.; yrs., 3 weeks mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 20th, 1847
(Month) (Day) (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stone
(b) General nature of industry, business, or establishment in which employed (or employer)..... work

9-BIRTHPLACE, (State or Country), Ohio.

PARENTS.

10-NAME OF FATHER, Jas. Jenkins.

11-BIRTHPLACE OF FATHER (State or Country). Unknown.

12-MAIDEN NAME OF MOTHER Mary McClure.

13-BIRTHPLACE OF MOTHER (State or Country). Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Delia Foutz

(Address) 1706 Montford ave., Balto.

15-

Filed SEP 30 1921 I. E. Wahal Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. Ross Insley M. D.
(Coroner.)

9-29-, 1921. (Address) 4 E. Eld

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ebenezer Cemetery, Md Carroll Co.	Oct 2, 1921
20-UNDERTAKER	ADDRESS
C. M. Watts.	Winfield, Md.

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Dorczek)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57336

CERTIFICATE OF DEATH.

153 D 57336

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 918 S. Fayette 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Anna Darczek,

(Residence in Baltimore: No. 918 S. Fayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Sgle

6-DATE OF BIRTH: Sept 11, 1821
(Month) (Day) (Year)

7-AGE: ....yrs. ....mos. 18 ds.
If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Curtis Bay Md

PARENTS.

10-NAME OF FATHER: Bronislaw Dorczek

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Janina Kosmaczewska

13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bronislaw Darczek

(Address) 918 S. Fayette St

15-

Filed ....., 191....

Robert F. Harrison,
Burial Permit Clerk. Registrar.

P 30792

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible]
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said [illegible]
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lack of Care

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner)

Sept 30, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sept. 30, 1921

20-UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank St

SCHEDULE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57337

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. 1306 ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Anthony Masterman

(a) RESIDENCE. NO. 3110 Auchentoroly Ter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella G. Mastermann

6 DATE OF BIRTH (month, day, and year) Nov. 15-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant 086

(b) General nature of industry, business, or establishment in which employed (or employer) Building Assn

(c) Name of employer Royal Oak Corp. Bldg Assn

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Charles B Masterman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theodore A. Masterman jr.
(Address) 3110 Auchentoroly Terrace.

15 Filed 3 Oct 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 29 1921

17 I HEREBY CERTIFY, That I attended deceased from September 27, 1921, to September 29, 1921, that I last saw him alive on September 29, 1921, and that death occurred, on the date stated above, at 1:35 A. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis
Cholelithiasis
Renal Disease

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Cholecystectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 28, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gaetano Pantheri, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 5th 1921
20 UNDERTAKER Wm J. Hartwell	ADDRESS 2232 W. Baltimore St.

IMPORTANT. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 57338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57338

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schroeder

(a) RESIDENCE. NO. 1517 Bank St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Carl Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1921, to Sept. 29, 1921, that I last saw him alive on September 29, 1921, and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray.

(Signed) J. E. Wallis Hull, M. D.

9/29/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery Rec'd 19

20 UNDERTAKER Clabt & Turner ADDRESS 14 N. Bway

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57339

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 W Calvert alley ST.) 17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Jones

(a) RESIDENCE. No. 519 W Calvert alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colard	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Jones

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER ~~Unknown~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Unknown~~

12 MAIDEN NAME OF MOTHER ~~Unknown~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Unknown~~

14 Informant Annie Jones

(Address) 519 W Calvert alley

15 Filed 3 01921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Sept 28, 1921, that I last saw h[illegible] alive on Sept 26, 1921, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. H. Slaughter M. D.

Sept 28, 1921 (Address) 1504 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 1 1921
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Cam ave

TION is very important. See instructions on back of certificates.

(Bruns)

HEALTH DEPARTMENT---CITY OF BALTIMORE

D. 57340

CERTIFICATE OF DEATH

~~57340~~ 41

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2 Main St. Arlington ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine C. Bruns

(Residence in Baltimore: No. 2 Main St. St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: 8 (Month) 11 (Day) 1921 (Year)

7-AGE: ..... yrs. 1 mos. 20 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): None 000

9-BIRTHPLACE (State or country): 2 Main St

PARENTS

10-NAME OF FATHER: Thomas J. Bruns

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Vida Lawrence

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. J. Bruns Sr. M.D.

(Address) 2 Main St.

15- Robert P. Harrison,

Filed SEP 30 1921, 191 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 9 (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/22, 1921, to 9/30 1921, that I saw h[er] alive on 9/30 1921, and that death occurred, on the date stated above, at 1045 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Bronchitis

(Duration) ..... yrs ..... mos. 8 ds.

Contributory (SECONDARY) Cardiac asthenia

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) Henry Russell M. D.

191..... [Address] 3902 Eastern Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Oct 1 191 1

20-UNDERTAKER: Henry Hovatter Son

ADDRESS: 1301 E Eager St

(Duplicate of certificate. ATION is very important. See instructions on back of certificate.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57341 ✓ 104 D 57341

CERTIFICATE OF DEATH.

REGISTERED NO. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1624 Chalk alley ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Dorsey

(Residence in Baltimore: No. 1624 Chalk alley St.; yrs., 3 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, June (Month) 20 (Day), 1921 (Year)

7-AGE, ...yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Infant

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, William Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Bessie Bacon

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bessie Dorsey

(Address) 1624 Chalk alley

OCT 1-1921 Robert P. Harris Registrar.

Filed ....., 191.....

Burial Permit .....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteric-Colitis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) ac. Bronchitis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. J. Hennessey M. D. (Coroner.)

Sept. 30. 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....dys. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 1. 1921

20-UNDERTAKER Brown & Fowlks — ADDRESS 1145 Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57342 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Banks

(a) RESIDENCE. No. 809 Vine st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Storeroom

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Grant Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Christina Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 OCT 1-1921 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1921, to Sept. 29, 1921, that I last saw him alive on Sept. 29, 1921, and that death occurred, on the date stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous arthritis right hip (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Padgett, M. D.

9-29-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 1 '21
20 UNDERTAKER	ADDRESS
Brown & Feelander	614 E

Instructions on back of certificates. See instructions on back of certificates.

Stars—6-9-19—H. P. Co.—1000 Blks.

D 57343 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 57343

CERTIFICATE OF DEATH.

REGISTERED NO. 1729

1-PLACE OF DEATH

CITY OF BALTIMORE: No 2439 N. Charles ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Milton Ingram

(a) RESIDENCE. No. 2439 N. Charles ST.; —— WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. ✱ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wyatt Hawkins Ingram

6 DATE OF BIRTH (month, day, and year) Nov. 7. 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lexington Kentucky

PARENTS

10 NAME OF FATHER Bushrod Taylor Milton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lexington Kentucky

12 MAIDEN NAME OF MOTHER Catherine Milton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Versailles Ky. (Mary Ann Claypoole)

14 Informant (Address) Dr Mary L. Ingram. 2439 N. Charles

15 Filed Robert P. Harrison, Registrar

1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 (6.10 am) 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1921, to Sept 30, 1921, that I last saw her alive on Sept 30 (6.10 am) 1921, and that death occurred, on the date stated above, at 6.10 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Lillian Rue Lebrites, M. D.

, 19 (Address) 1803 Calvert St Washington D.C.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 3 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E. Pratt

THIS is very important. See instructions on back of certificates.

Spec.—4-16-21—M&T—1500 Blks.

D 57344

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Schaffer 53 S Fulton

19 D 57344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2541 Frederick Ave 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Lee Mack

(a) RESIDENCE NO. 2541 Frederick St. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver U.S.

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Company

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albert P. Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Harriett Ramsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Harriett Mack

(Address) 2541 Frederick Ave

15 Filed ....., 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk

1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1921, to Sept 28, 1921, that I last saw him alive on Sept 28, 19..., and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas. A. Schaffer, M. D.

Sept 29 1921 (Address) 53 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Oct 1 1921

20 UNDERTAKER William Cook — ADDRESS 502 E. North Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57345

HEALTH DEPARTMENT—CITY OF BALTIMORE D 57345

CERTIFICATE OF DEATH.

134

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST.; 70 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Bass

(a) RESIDENCE. NO. 2010 Wilhelm ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Bass

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middlesex Co. Virginia

PARENTS

10 NAME OF FATHER George Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Co. Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Universal Hospital Records
(Address) Lombard & Greene Sts

15 Filed ....., 19.... M.F.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1921, to Sept 29, 1921, that I last saw h[er] alive on Sept 29, 1921, and that death occurred, on the date stated above, at 11 10 P m.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pregnancy Nephritis Toxemia

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 29 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

9 29. 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	OCT 2 1921
20 UNDERTAKER	ADDRESS
MR. & MRS. N. S. PINK, FUNERAL DIRECTORS, 1505 W. PRATT STREET	

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gant

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57346

CERTIFICATE OF DEATH.

5 170 D 57346

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N. Spring ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ambrose Gant

(a) RESIDENCE. NO. 418 N. Spring ST., 5 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Eliza. H. Gant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) at-home
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) born in Balto City and State

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) John James 621 Montgomery

15 Filed SEP 30 1921 19 M.F.W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1921, to Sept 29, 1921, that I last saw h[illegible] alive on Sept 29, 1921, and that death occurred, on the date stated above, at 11-40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? exam & urin

(Signed) Capt. J. L. Green, M. D.

9.30, 1921 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Glow Cem	Oct 2, 1921
20 UNDERTAKER	ADDRESS 1725- Eutaw St
Mrs. B. A. Elliott	

Read carefully back of certificates. See instructions on back of certificates. Items 1 to 15 are very important.

Spec.—8-24-14—M. & T.—2000 Bks.

57347 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 57347

X 126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 8 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Rose

(Residence in Baltimore: No. 1631 North Register St.; ....yrs., 1 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 8 (Day), 1844 (Year)

7-AGE, 77 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): G.S.B.

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Geo. W. Rose

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Catharine Hamilton

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Rose

(Address) Emmitsburg Md

15-

Filed ....., 191.... M.T.A.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 11 1921, to Sept 30 1921, that I saw him alive on September 30, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Post-Operative
Perineal Prostatectomy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cerebral Oedema

(Duration) ....yrs. ....mos. 3 ....ds.

(Signed) Charles A. Levy M. D.

Sept. 30, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Emmitsburg Md DATE OF BURIAL, Oct. 1, 1921

20-UNDERTAKER Robt. Shindler Jr. ADDRESS 1 & 24 Bway

Spec.—8-24-14—M. & T.—2000 Bks.

D 57348

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 57348

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1416 W. Lexington ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Augusta Hyatt

(Residence in Baltimore: No. 1416 W. Lexington St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, May (Month) 20 (Day), 1921 (Year)

7-AGE, ...yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Woodlawn, Balto Co.

PARENTS.

10-NAME OF FATHER, Jesse Hyatt

11-BIRTHPLACE OF FATHER (State or Country), New Market, Md.

12-MAIDEN NAME OF MOTHER, Mary A. Lilly

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Hyatt

(Address) 1416 W. Lexington St.

15-

Filed ..... 191. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1921, to Sept 29 1921, that I saw her alive on Sept 29 1921, and that death occurred, on the date stated above, at 8-40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gas-tro Enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry L. Dietz M. D.

Sept 29, 1921. (Address) 120 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Lorraine Cemetery

DATE OF BURIAL, 10-1-21

20-UNDERTAKER ROBERT BROOKS & SON

ADDRESS 1750 Calhoun St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1700 D 57349

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 N. Eden St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Underwood

(a) RESIDENCE. No. 304 N. Eden St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elijah Underwood

6 DATE OF BIRTH (month, day, and year) March 4, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER Luke Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Louisa Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co.

14 Informant Martha Wilkins
(Address) 304 N. Eden St.

15 Filed ....., 19.... Registrar

M7A.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/29, 1921, to 9/30, 1921, that I last saw h.er alive on 9/29, 1921, and that death occurred, on the date stated above, at 2.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) R. T. Hearn, M. D.

. 19 (Address) 1416 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sharp St. cemetery Chas rd.	Oct. 2, 1921
20 UNDERTAKER	ADDRESS
Miller Davis	317 N. Eden St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

57350

HEALTH DEPARTMENT—CITY OF BALTIMORE

57350

CERTIFICATE OF DEATH.

91-078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Fait Ave. + 41st (St.) No (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Hutchinson

(a) RESIDENCE. No. Fait Ave + 41st St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. 6 mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) April 1- 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	6	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) ..

(c) Name of employer ..

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER J. H. T. Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant J. H. T. Hutchinson
(Address) Fait Ave + 41st St.

15 Filed . 19 M7A. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1921, to Oct 1, 1921, that I last saw her alive on Sept 30, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. 1 mos. - ds.

CONTRIBUTORY (Secondary) Acut Myocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) W H B Tilden, M. D.

10/1, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: Oct. 3 1921

20 UNDERTAKER: Zirkler + Zirkler — ADDRESS: 1739 E. Eager

(Important. See instructions on back of certificates.)

Form—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57351

CERTIFICATE OF DEATH.

X 37 D 57351

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Snowden

(a) RESIDENCE. No..... Bowie Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bowie - md

PARENTS

10 NAME OF FATHER Albert Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Julia Fleet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Julia Fleet Bowie Md.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28 192

17 I HEREBY CERTIFY, That I attended deceased from 9-26 . 1921 . to 9-28 . 1921 . that I last saw h[illegible] alive on 9-28 . 1921 . and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? — Bowie Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. A. Holden M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL OCT 192 19

20 UNDERTAKER — Commissioner Health, Per. Wm. E. Woodall

ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should [illegible] that it may be properly classified. Exact statement of OCCUPA[illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

150858 Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57352

CERTIFICATE OF DEATH.

151 D 57352

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Hinton

(a) RESIDENCE NO. 1314 Myrtle Ave ST., II WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Hinton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Sarah Hicks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Johns Hopkins Hospital Recorder
(Address)

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 22nd, 1921, to Sept 29th, 1921, that I last saw her alive on Sept 29th, 1921, and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 22 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Bleau Dickson M. D.

9/29, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL OCT 1 1921 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57353 — X 92 D 57353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Wilensky

(Residence in Baltimore: No. Savannah Ga St.; ..... yrs., 10 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 43 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Baltimore St

15- GG

Filed OCT 1-1921, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/20/21 191, to 9/30/21 191, that I saw h.. alive on 9/30/21 191, and that death occurred, on the date stated above, at 11:50 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Myocardial failure

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Bright's Disease

..... (Duration) About 8 yrs. ..... mos. ..... ds.

(Signed) Louis Jaches M. D.

10/1/21, 191... (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State ..... yrs. 1 mos. 10 ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Savannah Ga

DATE OF BURIAL, 10/1, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57354

D 57354

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 S. Carlton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Robinson

(a) RESIDENCE. No. 20 S. Carlton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) 6/6/1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Augustin Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ella G Reaves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Ella Robinson
(Address) 20 S. Carlton st

15 Filed 1921 . 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1921, to Sept. 29, 1921, that I last saw h[illegible] alive on Sept. 29, 1921, and that death occurred, on the date stated above, at 7-55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

9-30-1921 (Address) 120½ Argyle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	OCT 2 1921
20 UNDERTAKER	ADDRESS
Samuel Saunders	578 W Biddle

Keep in a very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57355

CERTIFICATE OF DEATH

D 57355

37-091

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No..... ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cindia Eckans

(a) RESIDENCE. NO. 216 Rock ST., WARD.

(Usual place of abode) Unknown (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 49. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Andrew Watts 929 Greenmount ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 29, 21

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1. 19 21. to Sept 29. 19 21. that I last saw h alive on Sept. 29. 19 21. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Fever

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Serological findings

(Signed) H. Goldsmith M. D.

9/30/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 3 1921

20 UNDERTAKER: Samuel Hensley — ADDRESS: 5 S Wolfe

Check of certificates. See instructions on back of this copy. Important.

D 57356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57356

105

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 614 N. Hoffman ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Trilby B. Thomas

(Residence in Baltimore: No. 614 N. Hoffman St.: yrs. 24 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH, June (Month) 14 (Day), 1896 (Year)

7-AGE: 25 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: William Henry Thomas

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Sarah Carter

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sarah Carter

(Address) 614 W. Hoffman

15-

Filed ....., 191.... Registrar.

2-1921 Robert P. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held no inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute Dilatation of Heart

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) acute Dilatation of Heart

(Duration) yrs. mos. 1/2 ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Sept. 30, 1921 (Address) 2502 Frankstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Ft. Lincoln DATE OF BURIAL: ....., 1921

20-UNDERTAKER: Samuel Schumacher ADDRESS: 1780 Bridge

Important.—See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

(Sledz)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57357

CERTIFICATE OF DEATH.

104 D 57357

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Clement ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sledz

(a) RESIDENCE NO. 1606 Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of Industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Locust Point Md

PARENTS

10 NAME OF FATHER Peter Sledz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Krasniewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Helen Sledz

(Address) 1606 Clement St

15 Filed , 19 Robert F. Harrison, Registrar

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1921, to Sept 30, 1921, that I last saw him alive on Sept 30, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No

Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Kath E. Schmidt M. D.

19 (Address) 318 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Holy Cross A A Co	
20 UNDERTAKER John A Weber	ADDRESS 1803 Bank

ATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57358

CERTIFICATE OF DEATH.

170 D 57358

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1610 Forman St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Ann Barber

(a) RESIDENCE. No. 1610 Forman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Booker

6 DATE OF BIRTH (month, day, and year) Feb 22, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mins.
	72	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Petersburg, Va

PARENTS

10 NAME OF FATHER Isaac Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Dopheny Lynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Lucy Barber
(Address) 1610 Forman St

15 Filed Sept 30 2 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1921, to Sept 29, 1921, that I last saw h[illegible] alive on Sept 29, 1921, and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Age - Arterio Sclerosis (duration) yrs. 7 mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Physical

(Signed) William A Wright M. D.

Sept 30 1921 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Oct 2nd 1921
20 UNDERTAKER	ADDRESS
Sam'l H Chase & Son	1400 N Shen

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr. Schwatka

D 57359

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 57359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 S. Ellwood Ave ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick L. Berends

(a) RESIDENCE NO. 919 S. Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0ff0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick L. Berends

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma E. Moulstale

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Frederick L. Berends
(Address) 919 S. Ellwood Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 28th 1921, to Oct 1st 1921,
that I last saw him alive on Oct 1st 1921,
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Schwatka, M. D.

1921 (Address) 734 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	Oct 3 1921
20 UNDERTAKER	ADDRESS
A. Sander & Sons	1710 Fleet St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57360

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 S Bouldin ST., 76 WARD)

2-FULL NAME John H. Disney

(a) RESIDENCE NO. 146 S Bouldin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Life~~ 69 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Disney

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper. 008

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Carroll Co.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Oliver M. Disney

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Mary E. Disney
(Address) 146 S. Bouldin St.

15 Filed ....., 19 .....
Robert P. Harrison,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 25 1921 to Oct 1 1921, that I last saw h— alive on Sept 28 1921, and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Face — C.E.

Lip + tongue (duration) yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of St Agnes Hosp

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) Jno E O'Donovan M. D.

Oct 1, 1921 (Address) 125 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct 3 1921
20 UNDERTAKER	ADDRESS
H Sanders & Sons	1710 Fait St

SEE IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57361

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 S. Montford Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Single

(a) RESIDENCE NO. 725 S. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Single

6 DATE OF BIRTH (month, day, and year) Oct 5. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Klemm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Eck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Michael Single

(Address) 725 S. Montford Ave

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1921, to Sept. 29, 1921, that I last saw h alive on Sept. 27, 1921, and that death occurred, on the date stated above, at 1045 A. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Strangulated Hernia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Sign

(Signed) C. D. Neer, M. D.

10/1/21 (Address) 408 E Pat Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Oct 2 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57362

CERTIFICATE OF DEATH.

470 57362

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 529 Lamens ST.: 14th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bouldin

(a) RESIDENCE. No. 529 Lamens ST., 14 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 10 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. ... min.
	61 yrs.		2 days.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Chas. Manokey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliz Willett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Carrie Bouldin

(Address) 529 Lamens St.

15 Filed ..... 19.. Robert P. Harrison, Registrar

D — 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1921, to Sept 30, 1921, that I last saw h-er alive on Sept 30, 1921, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus (Operative)

(duration) Just Clear yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? 529 Lamens St

Did an operation precede death? Yes Date of 2nd Sept 24

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) ... M. D.

19 (Address) 1431 Fillmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 2 1921

20 UNDERTAKER: Geo. H. Holland ADDRESS: 1631 Druid Hill Ave.

This is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1600 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57363

CERTIFICATE OF DEATH.

D 57363

80

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Linden Ave St.; 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Hamburger

(a) RESIDENCE. No. 2213 Linden Ave St.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Jacob Hamburger

6 DATE OF BIRTH (month, day, and year): 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	✓			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Julius Moorhess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): J. Hamburger 2213 Linden Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

Oct 2 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Sept 30, 1921; that I last saw her alive on Sept 30, 1921; and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis, arteriosclerosis, angina pectoris. (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Frederick Lentz, M. D.

Oct 1 1921 (Address) 7040 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Oct 2 1921
20 UNDERTAKER	ADDRESS
J. Ahrens Co	1611 Mad Ave

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of each case. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen Hospital ST.; WARD)

REGISTERED NO. 170 D 57364

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Scott Child

(a) RESIDENCE. No. 1806 Bolton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Richard W. Child

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER Frank Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nellie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) V. Marchant 1806 Bolton St

15 Filed 12-1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased, from Oct 1st 21, 19, to Oct 2nd 21, 19, that I last saw h[er] alive on Oct 2nd 21, 19, and that death occurred, on the date stated above, at 8:35a m.

The CAUSE OF DEATH* was as follows: Chronic Hypertrophic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. ds.

18 Where was disease contracted if not at place of death? Gen Hosp Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter A. Carothers M. D.

, 19 (Address) M.D. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL Oct 3 1921

20 UNDERTAKER J. Ahrens & Co

ADDRESS 16th and Madison

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57365

CERTIFICATE OF DEATH.

64

D 57365

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Riggs Ave 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Barker

(a) RESIDENCE NO. 260[illegible] Riggs Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alethia J Barker

6 DATE OF BIRTH (month, day, and year) March 8/1845

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Track 073

(b) General nature of industry, business, or establishment in which employed (or employer) Walker

(c) Name of employer P. R. R. Co

9 BIRTHPLACE (city or town) (State or country) U. S. Co Md

PARENTS

10 NAME OF FATHER Henry Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Leah Shrenshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S. Co Md

14 Informant Wm E Barker

(Address) 2606 Riggs Ave

15 Filed ..., 19 ... Registrar

Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1. 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1920 to Oct 1 1921, that I last saw h[illegible] alive on Sept 30 1921 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) General Infirmities

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Murray, M. D.

, 19 (Address) 1221 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Severn Md.

DATE OF BURIAL Sept 4 1921

20 UNDERTAKER William Cook 502 E Natl Ave

ADDRESS

TION is very important. See instructions on back of certificate.

Murray 1221 W Lafayette Ave.

D 57366 HEALTH DEPARTMENT—CITY OF BALTIMORE 174 D 57366

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. B. & O. Riverside Round-house St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin F. Fleetwood.

(Residence in Baltimore: No. 2112 W. Lexington St. 8 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Divorced.

6-DATE OF BIRTH, Do not know. (Month) , 1 (Day) (Year)

7-AGE, 25 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Crane-operator.
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R.

9-BIRTHPLACE, (State or Country), Somerset Co. Md.

PARENTS.

10-NAME OF FATHER, George Fleetwood.

11-BIRTHPLACE OF FATHER (State or Country), Delaware.

12-MAIDEN NAME OF MOTHER, Sallie Miligan.

13-BIRTHPLACE OF MOTHER (State or Country), Somerset Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lucy Miller
(Address) 105 Market St. Pocomoke, Md.

15- Filed ..., 191...
Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 30th, 1921. (Month) (Day) , 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

fracture of the skull.
Accidental fall in revolving gears of a hoisting crane.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 2, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pocomoke City Md	Oct 3, 1921
20-UNDERTAKER John F. Denny,	ADDRESS 715 Light St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57367

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57367

CERTIFICATE OF DEATH.

63

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1926 N. Charles ST., 17 WARD)

2-FULL NAME Sarah Mumma

(a) RESIDENCE. No. 1926 N Charles ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos F. Mumma

6 DATE OF BIRTH (month, day, and year): Dec 16 1854

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md

PARENTS

10 NAME OF FATHER: Bragonier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Ida West

(Address) 1926 N Charles St

15 Filed ..... 19 .....

Registrar

Robert P. Harrison,

1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to Sept 30, 1921, that I last saw h... alive on Sept 30, 1921, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Pro Pressive central Muscular atrophy

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

Oct 4, 1921 (Address) 720 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisburg Pa	Oct 4 1921
20 UNDERTAKER	**ADDRESS**
Wm J. Ritter & Sons	North Pa

From is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57368

CERTIFICATE OF DEATH.

X91-1679 57368

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary (WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Bateman. Md. Cole.

(a) RESIDENCE. No. Federalsburg, Md ST., WARD. Federalsburg Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Wright.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Church Home & Infirmary Baltimore

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/19/, 1921, to 10/1/, 1921, that I last saw h.e.r alive on 10/1/, 1921, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia
Pulmonary Edema
following immunization of Contracted
Typ. under ob. Unsuccessful on
9/13/21 (duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Contracted Poliomyelitis
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 9/30/21

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A B Kyle M. D.

10/1, 1921 (Address) Church Home & Infirmary Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Federalsburg Md	Oct 2 1921
20 UNDERTAKER Wm T Tuckers Sons	ADDRESS Norfolk

Robert L. Harrison
-1921
Burial Permit Clerk.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57369

CERTIFICATE OF DEATH.

104

D 57369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Plymouth Ave St.: 13 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant May Feddeman

(a) RESIDENCE. No. 2016 Plymouth Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year) Dec. 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Balt md

PARENTS

10 NAME OF FATHER William J Feddeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Ruth C. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant Wm J Feddeman

(Address) 2016 Plymouth Ave

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1921, to Sept 30, 1921, that I last saw h[illegible] alive on Sept 29 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Ill-defined

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) T.B.F. Fuller, M. D.

Oct. 1921 (Address) N 27 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Oct 3 1921

20 UNDERTAKER: Chenowith Son — ADDRESS: Chestnut Ave

(Sec. 4 of Act of June 7, 1915, requires that a burial permit be obtained before any interment, removal, or cremation of a dead body. See instructions on back of certificates.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 57370

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1643 W. Lafayette Ave. (16th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Franklin Myers

(a) RESIDENCE. No. 1643 W. Lafayette Ave 16th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced Husband of — [redacted] Columbia Caroline Myers

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman - Canned Foods

(b) General nature of industry, business, or establishment in which employed (or employer) Canned Goods

(c) Name of employer Gulden Co of N.Y.

9 BIRTHPLACE (city or town) (State or country) Kingsport Tennessee

PARENTS

10 NAME OF FATHER David Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kingsport Tennessee, U.S.A.

12 MAIDEN NAME OF MOTHER Emeline Cloud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee USA

14 Informant (Address) Mrs. Nellie Markentz (daughter) 1643 W. Lafayette ave.

15 Filed OCT 3 - 1921, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Oct. 2nd, 1921, that I last saw h[im] alive on Oct. 2nd, 1921, and that death occurred, on the date stated above, at 6[15] p. m.

The CAUSE OF DEATH* was as follows:

(a) Diabetes (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

10/2/1921 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden	Oct 3/21 19

20 UNDERTAKER Wm. Loah. ADDRESS 502 E. Hart

Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57371

HEALTH DEPARTMENT—CITY OF BALTIMORE

57371

152 D 57371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Hugh Collier

(a) RESIDENCE. NO. Ellicott City, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24/1921

7 AGE — Years: ✓ — Months: ✓ — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Robt. S. Collier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ellicott City Maryland.

12 MAIDEN NAME OF MOTHER: Alice B. Daughters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Xenia Ohio.

14 Informant: Father Ellicott City
(Address) Maryland.

15 Filed OCT 3 - 1921, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1921, to Oct 2, 1921, that I last saw h[illegible] alive on Oct 2, 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Idiopathic Hemorrhage of Both Bones - (Internal)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) C W B Jones, M. D.

10/2 1921 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cemetery Ellicott City

DATE OF BURIAL: Oct 3 1921

20 UNDERTAKER: Scott M. Starr

ADDRESS: Ellicott City Md

THIS IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57372

HEALTH DEPARTMENT—CITY OF BALTIMORE

1920 D 57372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Edward McCall

(a) RESIDENCE. No. 730 Asquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb. 7 1881

7 AGE — Years: 40 Months: 7 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar - Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John McCall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Sarah J. McCready (Address) 1033 N. Carlton Ave

15 Filed OCT 3 1921, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1921, to Sept 30, 1921, that I last saw him alive on Sept. 30, 1921, and that death occurred, on the date stated above, at 1:05 P.m.

The CAUSE OF DEATH* was as follows:

Uremia

MVH

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Signs & Symptoms

(Signed) John F. Erwin, M. D.

, 19.... (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Oct 3 1921

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E. Northern

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.: Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis.

Spec.-1-10-21-M&T-1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57373 — 66 D 57373

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Russell ST., 21 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Stadtman

(a) RESIDENCE NO. 1204 Russell ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A Stadtman

6 DATE OF BIRTH (month, day, and year): Nov 25 1868

7 AGE: Years 53; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Peter Hueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Leffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John A Stadtman 1204 Russell St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1920 to Oct 1, 1921.

that I last saw h alive on Sept 31, 1921,

and that death occurred, on the date stated above, at 1.55 a m.

The CAUSE OF DEATH* was as follows:

Fall down steps
with contusion of Spine

(duration) — yrs. 9 mos — ds.

CONTRIBUTORY (Secondary): General paralysis

(duration) 1 yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Contusion of Spine

(Signed) Raymond Schmidt M. D.

Oct 1, 1921 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 4 1921

20 UNDERTAKER: Wm Cook — ADDRESS: 5326 E North Ave

Please write very important. See instructions on back of certificates.

St Hennessy Frederick
Linker

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 Nov 10 D 57374

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1817 Little Walsh St. 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick E Linker

(Residence in Baltimore: No. 1817 Little Walsh St. 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 23 (Day), 1846 (Year)

7-AGE, 75 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 041
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Royal Laundry

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Henry Linker

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Elyhna J

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henretta Linker

(Address) 1817 Walsh St.

15-

Filed....., 191..... JHS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 1, (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute peritonitis due to rupture of lower portion of ileum, caused by some external (accidental) violence (Duration)..... yrs. 18 hrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) J. S. Hennessy M. D. (Coroner.)

Oct. 2 1921 (Address) 7 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western — DATE OF BURIAL, Oct 3, 1921

20-UNDERTAKER Wellman Co 16 — ADDRESS 502 E Ka

(See instructions on back of certificate.)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57375

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 413 N. Calhoun ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Dudley

(a) RESIDENCE. No. 413 N. Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick M Dudley

6 DATE OF BIRTH (month, day, and year) Apr 28-1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73.	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER James Whitlock

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Frederick M Dudley
(Address) 413 N. Calhoun St

15 Filed ..., 19... Registrar

OCT 3-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to October 1, 1921, that I last saw her alive on September 30, 1921, and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(Mitral Stenosis)

(duration) ... yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Henry M. Alexander, M. D.

Oct 3 1921 (Address) 1022 West Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Oct 3. 1921

20 UNDERTAKER	ADDRESS
Wm Cook	502 E. North Ave

1022 W Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks.

D 67376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 57376

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Ausquith ST., 9 WARD)

2-FULL NAME Leah Hassan

(a) RESIDENCE No. 1814 Ausquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Gerdin J Wm & Hassan

6 DATE OF BIRTH (month, day, and year): March 18/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cecil Co Md

PARENTS

10 NAME OF FATHER: John Ebert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil Co Md

12 MAIDEN NAME OF MOTHER: Mary Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): George H Hassan 1814 Ausquith St

15 Filed OCT 3 1921, 19 ..... Registrar

Brumback 1531 E North Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to Oct 1, 1921, that I last saw her alive on Oct 1, 1921, and that death occurred, on the date stated above, at 11 10 a.m.

The CAUSE OF DEATH* was as follows:

Aortic & Mitral Regurgitation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? at Place of Duty

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. E. Brumbach M. D.

Oct 3 1921 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 6 1921

20 UNDERTAKER: W E Back — ADDRESS: 502 E North Ave

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57377

CERTIFICATE OF DEATH.

D 57377

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1407 W. Lexington ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie A Burnett

(Residence in Baltimore: No. 1407 W Lexington St. 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word): Married

6-DATE OF BIRTH: Oct 12, 1892 (Month) (Day) (Year)

7-AGE: about 29 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel A Burnett

(Address) 1407 W Lexington

15- OCT 3-1921

Filed ... 19... 191...

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct 1st, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or enquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis Ruptured duo decompos full term dead foetus in utero for about a month (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Colon Bacillus Injection? (Duration) yrs. mos. ds.

(Signed) Louis H Renlow M. D. (Coroner)

Oct 2 1921 (Address) 700 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1407 W. Lexington

19-PLACE OF BURIAL OR REMOVAL: Western Cem. DATE OF BURIAL: Oct 3 1921.

20-UNDERTAKER: William Col/C ADDRESS: 502 E. North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57378

CERTIFICATE OF DEATH.

28 D 57378

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cor Forrest & Chase ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Payne.

(Residence in Baltimore: No. Born in Balto St. Frances Convent Forrest & Chase Sts. 12 yrs., 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, 12 (Month) 23 (Day) 1905 (Year)

7-AGE,	If LESS than 1 day,
12 yrs. 7 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clarence Payne

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Lodie Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Mary Frances O.S.P.

(Address) St. Frances Convent & Chase St.

15-

Filed OCT 3-1921, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1921, to Sept 1921, that I saw her alive on Sept 12. 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mary F Voeglein M. D.

Sept. 30, 1921. (Address) 1028 Valley.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 3....., 1921

20-UNDERTAKER	ADDRESS
Felix B Pyn	102 Lombard St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57379

CERTIFICATE OF DEATH.

64 D 57379

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) 2669 Edmondson ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Schmidt

(a) RESIDENCE. No. 2669 Edmondson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Helen Schmidt

6 DATE OF BIRTH (month, day, and year) May 31 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher (retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 0/3

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Oldenburg Germany

PARENTS

10 NAME OF FATHER Thomas Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Vd. Kaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian Borchers

(Address) 612 N. Monroe St.

15 Filed OCT 3 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30th 1921, to Oct 1 1921,

that I last saw him alive on Oct 1 1921,

and that death occurred, on the date stated above, at 5. 15 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank N. Hillis, M. D.

, 19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 4 1921
20 UNDERTAKER Geo J. Smith	ADDRESS 1000 Fayette E

Keep this copy for reference. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57380

CERTIFICATE OF DEATH.

15 D 57380

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 60 N. Mount ST.: 16 WARD)

(Stillborn)

2-FULL NAME Baby Dennis

(a) RESIDENCE. NO. 60 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Herr Dennis

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Hagenfuss

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Theodore V. Dennis
(Address) 607 N. Mount St

15 Filed OCT 3 1921, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 21, to Oct 1, 19 21, that I last saw h alive on Oct 1, 19 21, and that death occurred, on the date stated above, at 10, 0. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia 20 min
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harwood Kalb, M. D.

Oct 3, 19 21 (Address) 1127 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 3, 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 W. Fayette St

Note.—Key important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50D 57381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Clarks Lane Park Heights Ave. WARD) 27

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Reindollar

(a) RESIDENCE. No. Clarks Lane Bancroft Park ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Louise Reindollar

6 DATE OF BIRTH (month, day, and year) Oct 16. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg. Sales Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 686

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob J. Reindollar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Bernay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) George E. Reindollar Clarks Lane

15 Filed OCT 3 - 1921 19 Registrar GL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1913, to Oct 1, 1921, that I last saw him alive on Oct 1, 1921, and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Dr. Schulmi

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) J. Brown Gibson, M. D.

, 19 (Address) 1001 E Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Oct 3 1921

20 UNDERTAKER John Ottetchell ADDRESS 1901 W. Fayette St.

Keep in a dry place. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57382

CERTIFICATE OF DEATH.

1130 57382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 W. Fayette ST.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella F. Kane

(Residence in Baltimore: No. 1202 W. Fayette St.; 23 yrs., 2 mos. 6 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH. July (Month) 3 (Day), 1833 (Year)

7-AGE.	If LESS than 1 day,
68 yrs. 2 mos. 28 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE. (State or Country). Wisconsin

PARENTS.

10-NAME OF FATHER. Silas S. Fuller

11-BIRTHPLACE OF FATHER (State or Country). Mass

12-MAIDEN NAME OF MOTHER Melissa H. Fisk

13-BIRTHPLACE OF MOTHER (State or Country). Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ellen M. Newton

(Address) 1202 W. Fayette St.

15-

Filed....., 191.....

Registrar.

OCT 3-1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 1 1921, to Oct 1 1921, that I saw her alive on Oct 1 1921, and that death occurred, on the date stated above, at 12-30 P.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) Years 6 mos. da.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. da.

(Signed) Henry C. Blake M. D.

Oct 1, 1921. (Address) 1203 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Oct 3 1921
20-UNDERTAKER	ADDRESS
John O'Meara (Son)	W. Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57383

CERTIFICATE OF DEATH.

144 D 57383

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division Street ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette Martin (Miss)

(a) RESIDENCE. No. 26 E. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary to Dr

(b) General nature of industry, business, or establishment in which employed (or employer) Doctor's office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Marlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George A Marlow
(Address) 26 E Lanvale

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1921

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1921, to Sept 30, 1921,

that I last saw her alive on Sept 30, 1921,

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Multiple lung abscesses (rt.)

(duration) yrs. 4 mos. ? ds.

CONTRIBUTORY (Secondary) Cerebral abscess

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 30, '21

Was there an autopsy? No

What test confirmed diagnosis? X-ray pictures

(Signed) Jno. Finney, M. D.

Sept 30 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Oct 3 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W Fayette

GIVE INSTRUCTIONS ON BACK OF CERTIFICATE.

Mad 2252

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57384

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57384

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 349 S. Monroe St. ST.: 19 WARD)

2-FULL NAME Annie M. Kanely

(a) RESIDENCE. NO. 349 S. Monroe ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Kanely

6 DATE OF BIRTH (month, day, and year) Feb. 23, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Mc Cauley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

Informant Chas N. Kanely (Address) 3242 O'Donnell St.

Filed OCT 3 1921, 19.... Registrar John Mitchell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1921, to Oct 1, 1921

that I last saw her alive on Oct 1, 1921

and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Resp Intestinal

(duration) yrs. mon. ds.

CONTRIBUTORY (Secondary) Chronic Cons

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Thos Cleaves M. D.

Oct 2, 1921 (Address) 3450 Dillon Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet DATE OF BURIAL Oct 4 1921

20 UNDERTAKER John Mitchell ADDRESS 1201 N. Fayette St.

Alberto Wright

D 57385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57385

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 112 n Caroline St.: 5 WARD)

REGISTERED No. C 792

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alberto Wright

(Residence in Baltimore: No. 112 n Caroline St.: 24 yrs., mos ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	Col.	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
24 yrs. mos. ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Wright

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ella Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Wright

(Address) 1825 Madison St.

15-

Filed ..... 191.....

Registrar.

OCT 5 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Ansell M. D. (Coroner.)

9-30 1921 (Address) 41 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Arnold Station	Oct 3, 1921

20-UNDERTAKER	ADDRESS
Lee G. Cook	North & Ha. Ford

See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 & Preston

D 57386

57386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 E. Fayette ST., 6 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Bozman

(a) RESIDENCE NO. 2219 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charlotte Bozman

6 DATE OF BIRTH (month, day, and year) March 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cecil
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bozman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant W. L. Muir
(Address) 2219 E. Fayette St

15 Filed ....., 19.... Registrar

OCT 3 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Oct 3, 1921, that I last saw h- alive on Oct 2, 1921, and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nep-hritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? No

What test confirmed diagnosis? Usual Urinalysis

(Signed) Ralph L Stoyt, M. D.

, 19 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cecil Somerset Co. Md.	Oct 4 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Pied St

HOW TO FILL OUT CERTIFICATE. See instructions on back of certificates. Items are very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57387

CERTIFICATE OF DEATH.

120 D 57387

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 43 Raspe Ave. Raspeburg ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Fowler

(a) RESIDENCE NO. 43 Raspe Ave. Raspeburg WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane Fowler

6 DATE OF BIRTH (month, day, and year) March 2nd 1828

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Savings Bank~~ Savings Bank

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland

PARENTS

10 NAME OF FATHER ~~Benjamin~~ Fowler

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Maryland

12 MAIDEN NAME OF MOTHER ~~Ellen~~ Fryle

13 BIRTHPLACE OF MOTHER (city or town) Prince George's Co. (State or country) Maryland

14 Informant James H. Fowler (Address) 43 Raspe Ave. Raspeburg

15 Filed OCT 2 1921 H E Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1920, to Oct 2 1921.

that I last saw him alive on Oct 1 1921,

and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Intestinal Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G. Hebden, M. D.

, 19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 4th 1921
20 UNDERTAKER	ADDRESS
Frederick Lassahn Sons	Fullerton

Make duplicate of certificates. See instructions on back of original.

TATES

Spec.—8-24-14—M. & T.—2000 Bks.

D 57388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57388

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 Alford ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Tates

(Residence in Baltimore: No. 523 Alford St.; 70 yrs., ... mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED? (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ... (Day) 1847 (Year)

7-AGE, 71 yrs. ... mos. ... da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) ...

086

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Tunnell Tilson

(Address) 703 Alford St

15-

Filed ..., 191. M.T.A. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 29, 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 22 1914, to Sept. 29 1914, that I saw h— alive on Sept. 29 1914, and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 8 da.

CONTRIBUTORY (Secondary) Coma

(Duration) ... yrs. ... mos. 2 da.

(Signed) ... M. D.

Oct 2, 191. (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 3, 191.

20-UNDERTAKER, Samuel T Hemsley — ADDRESS 3810 Bridle

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57389

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. Municipal Tuberculosis Hospital 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Walter

(a) RESIDENCE. NO. 726 N. Caroline st. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 44 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Walter

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Isaac Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Gail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M.T.H.

15 Filed ..... 19 M.J.O Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29 1921, to Sept. 30 1921, that I last saw him alive on Sept. 29 1921, and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis Donaghue M. D.

9-30-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Oct 3 1921
20 UNDERTAKER John W Henderson	ADDRESS 1501 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57390

170

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 107. Barney St. St.: 23 Ward)

2-FULL NAME Charles H. Baker

(a) RESIDENCE. No. 104. Barney St. St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 6 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Baker

6 DATE OF BIRTH (month, day, and year) April 2. 18

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	5.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman 073

(b) General nature of industry, business, or establishment in which employed (or employer) Western Maryland R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER John H. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Wehrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Germany

Informant Carrie Wagner

(Address) 104. Barney St

Filed ... 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 30, 1921, that I last saw him alive on Sept 30, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam of urine

(Signed) Robert J. Green, M. D.

10-3, 1921 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak. Lawn. Cemetery	Oct 3, 1921
20 UNDERTAKER	ADDRESS
Wendell Lippel & Son	57 Nine St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57391 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57391

CERTIFICATE OF DEATH.

X 1405

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. ..... ST.: ..... WARD)

2-FULL NAME Hilbert John Bricker

(a) RESIDENCE. No. 459 12th St. Niagara Falls N.Y. St., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 28 ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Agnes Bricker

6 DATE OF BIRTH (month, day, and year) Mch. 18, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Electric Power plant

(c) Name of employer Niagara Falls Power Co.

9 BIRTHPLACE (city or town) (State or country) youngstown Ohio

PARENTS

10 NAME OF FATHER Ezra J. Bricker

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) unknown

12 MAIDEN NAME OF MOTHER Alice Haberstick

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Unknown

14 Informant Agnes Bricker (wife)
(Address) 459 12th. St Niagara Falls

15 Filed ..... 19 M 7 9. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1921, to October 2, 1921, that I last saw h.im alive on October 2, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebellar Neoplasm

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 12, 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Gaetano Panettieri M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Niagara Falls	10-3-21 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Brdwy

...back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57392 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ H 0 D 57392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 N.Broadway ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Bramble

(a) RESIDENCE. No. 1013 N.Broadway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of John T.Bramble

6 DATE OF BIRTH (month, day, and year) Dec 5.1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Wm.b.Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Mary Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Katherine B.Magill
(Address) 1013n.Broadway

15 Filed 3-1921, 19 M79 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.30.1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1920, to Sept 30, 1921, that I last saw her alive on Sept 30, 1921, and that death occurred, on the date stated above, at 10.10 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? X ray + clinical test

(Signed) A.L.Macdonald, M. D.

Oct 1, 1921 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 3-21 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

...on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57393

D 57393

78

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921-W. Lexington St.: 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Dunn

(a) RESIDENCE No. 921 W Lexington St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William A Dunn

6 DATE OF BIRTH (month, day, and year): Dec.

7 AGE — Years: 56 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas. Dupont

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Cecilia. A Dunn 921 W. Lexington

15 Filed ... 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20th 1921, to Oct. 1st 1921, that I last saw her alive on Sept 29th 1921, and that death occurred, on the date stated above, at 8 10 a m

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ray D McClory, M. D.

, 19 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	8-4-1921
20 UNDERTAKER: H. C Branning & Son	ADDRESS 517 N. Schroeder St

This is very important. See instructions on back of certificates.

D 57394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57394

CERTIFICATE OF DEATH.

(PLACE OF DEATH

REGISTERED No. C 29

CITY OF BALTIMORE (No. Boulevard Apt. St. Paul & 32 ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kester Bonnell

(Residence in Baltimore: No. Boulevard Apt. St. Paul & 32 nd. St St. 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, February (Month) 13 (Day), 1878 (Year)

7-AGE, 43 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Professor 069
(b) General nature of industry, business, or establishment in which employed (or employer)..... Teacher Goucher College

9-BIRTHPLACE, (State or Country), Seattle Washington

PARENTS.

10-NAME OF FATHER, Charles R Bonnell

11-BIRTHPLACE OF FATHER (State or Country), Phila. Pa.

12-MAIDEN NAME OF MOTHER Elizabeth Kester

13-BIRTHPLACE OF MOTHER (State or Country), Phila. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J.K. Bonnell (Wife)

(Address) Boulevard Apt. St. Paul & 32 St

15- Oct 9 1921

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Vascular disease of heart

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) John F. Morrison M. D. (Coroner.)

Oct 8 1921 (Address) 3632 Boulevard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa.

DATE OF BURIAL, 10/4/21 19....

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODS, Manager)

ADDRESS 108 W. NORTH AVE.

Important: See instructions on back of certificate. Insert statement of OCCUPATION in every case.

Spec.—1-10-21—M&T—1500 Bks.

D 57395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 1921 24 1899

D 57395

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Presbman St. 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Eggnel Thomas

(a) RESIDENCE NO. 1718 Presbman St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1897

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
24	8	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) city

PARENTS

10 NAME OF FATHER Benjamin Gray.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jackson Buscoe
(Address) 1718 Presbman St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1921, to Sept 30, 1921, that I last saw h alive on Sept 30, 1921, and that death occurred, on the date stated above, at 3.50 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs ... mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? none Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Cleaver, M. D.

1921 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct 4th 1921

20 UNDERTAKER Charles L Wright

ADDRESS 1569 Carey

Note—Very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57396

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 Christian St. ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rachel Nichols

(a) RESIDENCE. NO. 1932 Christian ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1921	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ada Fifel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas Nichols
(Address) 1932 Christian St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-1921

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1921, to 4/29, 1921, that I last saw her alive on 4/29, 1921, and that death occurred, on the date stated above, at 10.25a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 6 mos. 24 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical -

(Signed) E. Hollis Hamm, M. D.

May 1, 1921 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 3 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schmatz & Bro	2101 Park Ave

Fill out all blanks. Do not write on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bkr.

[redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57397

D 57397 [redacted]

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 Foster Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob W. Kahler

(a) RESIDENCE. NO. 2529 Foster ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 30, 1921

7 AGE Years Months Days If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jacob P. Kahler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Barbara Palasek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jacob P. Kahler

(Address): 2529 Foster Ave.

15 Filed OCT 3 1921, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/30 19 21

17 I HEREBY CERTIFY, That I attended deceased from 9/30, 19 21, to 9/30, 19 21,

that I last saw h[illegible] alive on 9/30, 19 21,

and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Asthenia & Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Henry A. Antkoff, M. D.

9/1, 1921 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: Oct 1 1921

UNDERTAKER: Mrs Falkowski

ADDRESS: 618 Eastern Ave

Back of certificates. Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 28 D 57398

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Maude Howell Sayar

(a) RESIDENCE No. 302 Roberts ST., WARD Kaywood N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced ~~WIFE~~ of (or) WIFE of Frank Dominic Sayar

6 DATE OF BIRTH (month, day, and year) Mar. 17th 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	6	~~27~~ 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Flanders
(State or country) New Jersey

PARENTS

10 NAME OF FATHER Silas A. Howell

11 BIRTHPLACE OF FATHER (city or town) Flanders
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Kate Miller

13 BIRTHPLACE OF MOTHER (city or town) Lodi
(State or country) New York

14 Informant Frederick D. Sayer
(Address) 302 Roberts Av

15 Filed . 19 M7A. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18th, 1920, to Oct. 3, 1920, that I last saw her alive on Oct. 3, 1920, and that death occurred, on the date stated above, at 1 35 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos 18 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 5-6 mos. ds.

18 Where was disease contracted if not at place of death? Kaywood, N. Y.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray + Stained Sputum Smears

(Signed) G. F. Goff M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Geneva, New York	Oct 3 1921
20 UNDERTAKER Philip Deming	ADDRESS 2016 Eutaw St

See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57399 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57399

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sayar

(a) RESIDENCE NO. 302 Roberts St. (mothers address) ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... (None)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank A. Sayar

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) New York City

12 MAIDEN NAME OF MOTHER Maude Howell

13 BIRTHPLACE OF MOTHER (city or town) Flanders
(State or country) New Jersey

14 Informant Frank A. Sayar
(Address) 302 Roberts St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from 7:25 PM Oct. 2, 1921, to 10:45 PM Oct 2, 1921, that I last saw her alive on Oct. 2, 1921, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Pregnancy of 5 to 6 mo. duration)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (mother)

(duration) ..... yrs. 2 mos. 18 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. F. Goff M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Geneva, New York	Oct. 3rd 1921
20 UNDERTAKER	ADDRESS
Philip Herwig	Orleans 2016

Instructions on back of certificates. See instructions on back of certificates. Every question important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 57400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 D 57400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Fillmore St. St.: 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Joseph Catitton

(a) RESIDENCE. No. 1119 Fillmore St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Catitton

6 DATE OF BIRTH (month, day, and year) Abt. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Abt. 60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William D. Holloway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. I. H. Mose (Address) 5315 York Road

15 Filed OCT 3 - 1921 . 19 H. H. Helms Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 . 1921 to Oct 1 . 1921.

that I last saw her alive on Sept 29 . 1921.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Endocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Gutsch M. D.

Oct 3 1921 (Address) 515 Shellman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Oct 3rd 1921
20 UNDERTAKER Joseph B. Cook.	ADDRESS 1003 N Gilmor St

(Fill out all items if possible. See instructions on back of certificates.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57401 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 19 D 57401

1-PLACE OF DEATH Alice S Kidd REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital St. 16 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs alice K idd -

(a) RESIDENCE. No. 1 Kenwood ave - St., Ward. -
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	m -

5a If married, widowed, or divorced (or) WIFE of John P K idd -

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md -

PARENTS

10 NAME OF FATHER John W Kenny

11 BIRTHPLACE OF FATHER (city or town) Balto. Co -
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Hennings

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Mr John S. Kidd
(Address) 1 Kenwood Ave (Kenwood Park)

15 Filed OCT 3-1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-16-21, 19, to 10-2-, 1921, that I last saw her alive on 10-2, 1921, and that death occurred, on the date stated above, at 7.25 A. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency and

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Myocardial & Renal insuff

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) S. A. Holden. M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 5 1921
20 UNDERTAKER	ADDRESS
Kenly Storch & Sons	1301 E Eager St

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57402

CERTIFICATE OF DEATH.

40 D 57402

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Stirling ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Guilta

(a) RESIDENCE NO. 1018 Stirling ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. — mos. — ds. How long in U. S., if of foreign birth? 31 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Barbetta Guilta

6 DATE OF BIRTH (month, day, and year) March 9 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	56	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street paver for

(b) General nature of industry, business, or establishment in which employed (or employer) United Railway

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Guilla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Hosvogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Barbetta Guilla

(Address) 1018 Stirling St

15 Filed OCT 3- 1921 J. E. Kehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from ~~Aug~~ April 21, to Oct 2, 1921, that I last saw him alive on Sept. 30, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Duration about 8 to 12 mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hard irregular mass Cardial end stomach

(Signed) W. J. Riley, M. D.

19 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 5 1921
20 UNDERTAKER Henry Horck Son	ADDRESS 1301 E Eager

SECTION 15 very important. See instructions on back of certificates. DEPARTMENT OF OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 57403

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57403

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1051 Harford Ave ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen M. Young

(a) RESIDENCE NO. 1051 Harford Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Late Samuel R. Young

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John J. Hearne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Robert F. Hearne

(Address) 1051 Harford Ave

15 Filed OCT 3 1921 H. M. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1921, to Oct 2nd 1921, that I last saw h[e] alive on Oct 1st, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Uremic Carcinoma Pylorus

Contributory Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno S Horsley, M. D.

Oct 7, 1921 (Address) 500 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct. 5 1921
20 UNDERTAKER	ADDRESS
Henry Storch Son	1301 E Eager

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57404 ✓ D 57404

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 1510 Latrobe Terrace ST.; 24 WARD)

2-FULL NAME Amos James Blinke

(a) RESIDENCE. No. 1510 Latrobe Terrace ST.; 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov 20 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Blinke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Cademore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Blinke
(Address) 1510 Latrobe Terrace

15 Filed OCT 3 19 1921 J. E. Mehrn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to Oct 2nd, 1921, that I last saw h... alive on ... 19..., and that death occurred, on the date stated above, at 9 25A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical symptoms

(Signed) L. V. Leppard, M. D.

(Address) 423 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	10-4 1921

20 UNDERTAKER Erb Hauke ADDRESS 115 E Lexington St.

(1) See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57405

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 2208 Druid Hill Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Chesley

(a) RESIDENCE. No 2208 Druid Hill ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE Years 49 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Priv

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Nellie Coulter
(Address) 1625 Druid Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1921, to Sept 28, 1921, that I last saw her alive on Sept 28, 1921, and that death occurred, on the date stated above, at 2:00 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Cirrhosis of

(duration) 2 yrs. 2 Weeks ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. P. Beyki, M. D.

19 (Address) 618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Sept. 4 19

20 UNDERTAKER: James H. Dunn — ADDRESS: 203 Fremont

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic constipation
Torbid liver which
condition caused
gastritis

Halloway

D 57406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57406

CERTIFICATE OF DEATH.

71

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 313 N Stricker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Halloway

(Residence in Baltimore: No. 313 N Stricker St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH: June (Month) 8 (Day), 1917 (Year)

7-AGE: yrs. 3 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: James Halloway

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Anne Brooks

13-BIRTHPLACE OF MOTHER (State or Country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Anna Halloway

(Address): 323 N Stricker St

15-

Filed ....., 19.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions due to Some Unknown Natural Cause

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Preston M. D. (Coroner.)

Oct 1, 1921. (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, ..., 19....

20-UNDERTAKER, Samuel A. Davis — ADDRESS, 312 Druid Hill Ave

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

57407

HEALTH DEPARTMENT—CITY OF BALTIMORE

57407

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 W. 24th ST., 17 WARD)

2-FULL NAME Mary Louise Ament

(a) RESIDENCE NO. 433 W. 24th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 5th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W. Ament

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth W Houston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) John W. Ament 433 W. 24th St

15 Filed 3 1921, 19 Wm A Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 19 21, to 10/1, 19 21.

That I last saw her alive on 10/1, 19 21, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus and inanition

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) General weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. Slayden Graves M.D.

10/2, 1921 (Address) 1900 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 4th 1921

20 UNDERTAKER George Schilling & Sons — ADDRESS Mt Royal Ave & Lanvale St

Check of certificates. See instructions on back of certificate. Important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Autopsied

Child's father confirmed epileptic Wassermann's proved negative. Child was idiot from time of birth. No further history than general wasting away. No gastro intestinal disturbance

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57408

CERTIFICATE OF DEATH.

D 57408

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 N Central Ave. WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Euald

(a) RESIDENCE No. 1409 N Central Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Euald

6 DATE OF BIRTH (month, day, and year): Sept 26/1861

7 AGE — Years: 60 — Months: — — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mehrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Barbara Euald 1409 N Central Ave

15 Filed 1921 Robert P. Harrison, Registrar

Call 1200 Butler Park Hu Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept-1, 1921, to Oct-2, 1921, that I last saw him alive on Oct-1, 1921 and that death occurred, on the date stated above, at 12 25 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Rectal Examination

(Signed) C. G. Hall, M. D.

Oct 3 1921 (Address) 1617 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Oct 4 1921

20 UNDERTAKER: Wm Cook 502 E Saratoga — ADDRESS

IMPORTANT See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57409

CERTIFICATE OF DEATH.

D 57409

REGISTERED No. C x 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 Collings ave St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Hines Thomas

(Residence in Baltimore: No. 314 Collings ave St.; ... yrs., 6 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Sept 23, 1866 (Month) (Day) (Year)

7-AGE, 65 yrs. 9 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Horticulturist
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Chestertown Md

PARENTS.

10-NAME OF FATHER, John E Thomas

11-BIRTHPLACE OF FATHER (State or Country), Kent Co Md

12-MAIDEN NAME OF MOTHER Laura E Tilden

13-BIRTHPLACE OF MOTHER (State or Country), Kent Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Harvey Thomas

(Address) 612 E. 41 Street

15- ...

Filed ..., 191... Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3, 1911. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1911, to Oct 3 1911, that I saw h— alive on Oct 2 1911, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

..., 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence Chestertown Md.

19-PLACE OF BURIAL OR REMOVAL, Rock Hall Kent Co Md. DATE OF BURIAL, Oct 4, 1911.

20-UNDERTAKER Wm Cook ADDRESS 502 E Fayette

(Balto & Eastern Shore Boat) c/o W. H. Francis.

Supplement. See instructions on back of certificate.

D 57410 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57410

CERTIFICATE OF DEATH. 183

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 223 W. Chase St.: 11 WARD) REGISTERED No. C

2-FULL NAME Beatrice Ackwood (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 223 W. Chase St. St.: 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) single

6-DATE OF BIRTH. ..... Jan. 13, ..., 1904 (Month) (Day) (Year)

7-AGE. ..... 17 yrs. 9 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Maid
(b) General nature of industry, business, or establishment in which employed (or employer)..... 970.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Ackwood

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ellen Myers

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ellen Ackwood

(Address) 223 W. Chase St.

15-

Filed ....., 191..... Robert P. Hartley, Clerk.
Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage due to stab wounds of throat. Heart & lung also immediate death

..... (Duration) ..... yrs. 0 mos. ..... ds.

CONTRIBUTORY (Secondary) Homicidal.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D. (Coroner)

Oct. 3, 1921 (Address) 250 N. Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn | DATE OF BURIAL, Oct. 4, 1921

20-UNDERTAKER Daniel Carron | ADDRESS 916 Edmondson Ave.

Date of Extraction of Occupation is on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 57411

1-PLACE OF DEATH

CITY OF BALTIMORE: No 2208 Christian St. St.; 21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph D. Ward

(a) RESIDENCE No. 2208 Christian St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		Oct.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury Md

12 MAIDEN NAME OF MOTHER M. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Willie Ward
(Address) 2208 Christian St

15 Filed 3-1921 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Oct 1, 1921, that I last saw him alive on Oct 1, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Nonclosure of Foramen Ovale.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Hutzler M. D.

9/3/21 (Address) 2161 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct. 4 1921

20 UNDERTAKER Leo F. Cook

ADDRESS North & Harford Ave

(Helen Leddon) D 57412

D 57412

STATE OF MARYLAND
CERTIFICATE OF DEATH

PLACE OF DEATH D 57412

Registration Dist. No. .....

y .....

or City Balto (No. 1710 N Chapel St.; ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Helen H Leddon

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

TE OF BIRTH March 12th, 1[illegible]
(Month) (Day) (Year)

E ..... yrs. ..... mos. 21 da. | If LESS than 1 day ..... hrs. or ..... min. ?

CCUPATION
) Trade, profession or rticular kind of work None
) General nature of industry usiness, or establishment in hich employed or (employer) .....

IRTHPLACE (State or country) Balto Co

10 NAME OF FATHER Wm. R. Leddon

11 BIRTHPLACE OF FATHER (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Helen Cutler

3 BIRTHPLACE OF MOTHER (State or country) Cumberland Md

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant) Irving B Leddon

(Address) 1710 N Chapel St

Robert F. Harrison,
192 Registrar
1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 3rd, 1921
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 29th, 1921, to Oct 3rd, 1921, that I last saw her alive on Oct 1st, 1921, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH * was as follows:

Influenza

..... (Duration) ..... yrs. ..... mos. 7 ds.

Contributory Secondary Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Ed Stevens M. D.

Oct 3rd, 1921 (Address) 1407 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... da. In the State, ... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Old St Paul cem | DATE OF BURIAL: Oct 4, 1921

20 UNDERTAKER: Wm Cook | ADDRESS: 502 E North Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Spec.—5-19-13—M. & T.—500 Bks.

57413

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-15 57413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 Moore ST.: 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Evelyn Carter

(Residence in Baltimore: No. 546 Moore St.: yrs. 5 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. April (Month) 21 (Day), 1921 (Year)

7-AGE. yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore - Md.

PARENTS.

10-NAME OF FATHER. Robert Carter

11-BIRTHPLACE OF FATHER (State or Country). Baltimore - Md

12-MAIDEN NAME OF MOTHER Sarah Dorsey

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Dorsey

(Address) 546 Moore St.

15-

Robert F. Harrison,

Filed....., 191.....

Registrar.

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October (Month) 2nd (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 29 1921, to Oct. 2nd 1921, that I saw her alive on Sept. 29 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchio - pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) yrs. mos. ds.

(Signed) Bertha E. Topmen M. D.

Oct. 3, 1921. (Address) 2730 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Bth Interment

DATE OF BURIAL, Oct 4, 1921.

20-UNDERTAKER Hamm & Hemler

ADDRESS 2711 Belair St

Spec.—1-10-21—M&T—1500 Blks.

150878 D 57414

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57414 104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, No. WARD)

2-FULL NAME Harry Meyers

(a) RESIDENCE NO. 3719 Mt. Pleasant Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 20, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Henry L. Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Kelly Fanning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto? Md

14 Informant Records J.H.H.
(Address)

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 23rd, 1921, to Oct 3rd, 1921, that I last saw h in alive on Oct 3rd, 1921, and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

10/3, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Oct 4 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Eden St

Robert P. Harrison,
1921 Burial Permit Clerk.

From every important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57415

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 57415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 S Kenwood ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jonciewski

(a) RESIDENCE NO. 832 S Kenwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED — None

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Paul Jonciewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Borkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Paul Jonciewski 832 S Kenwood

15 Filed 1921, 19 G. G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1921, to Oct 3, 1921, that I last saw h— alive on Oct 3, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

(a) Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Gomel M. D.

19 Address 801 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Oct 4 1921

20 UNDERTAKER: John M Weber — ADDRESS: 1303 Banket

Please be very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57416

CERTIFICATE OF DEATH.

64 D 57416

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 E Hoffman ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothea Schmidt

(Residence in Baltimore: No. 2304 E Hoffman St.; 56 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, or DIVORCED,~~ Married (Write the word.)

6-DATE OF BIRTH, March (Month) 31 (Day), 1865 (Year)

7-AGE, 56 yrs. 6 mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 237

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Conrad Roider

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Miller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustav H Schmidt

(Address) 2307 E Hoffman St

15- OCT 4 - 1927

Filed....., 191.... F.E.Weber Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 12th (Day), 1927 (Year)

17-I HEREBY CERTIFY, That I attended deceased from February 2nd 1927, to October 12th 1927, that I saw h[illegible] alive on October 12th 1927, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Arteritis Rheumatism

(Duration) yrs. 8 mos.....ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 2 mos. 2 days

(Signed) P E Fiddy M. D.

Oct 3rd 1927 (Address) 810 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Oct 4, 1927

20-UNDERTAKER John Herring & Co

ADDRESS 2008 Orleans

Spec.—8-24-14—M. & T.—2000 Bks.

D 57417 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57417

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1103 Ward St.: 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane F. L. A. L. Mangold

(Residence in Baltimore: No. 1103 Ward St St.: 50 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, June 8, 1856
(Month) (Day) (Year)

7-AGE 65 4 26
yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Q40

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER Wm Mangold

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Marie Rosa

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Mangold

(Address) 113 S Carroll

15-

Filed OCT 5 - 1914, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1914
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1914, to Oct 3 1914, that I saw h[illegible] alive on Oct 3 1914, and that death occurred, on the date stated above, at 9 45 m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

Senile Gangrene

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) 7 yrs. mos. ds.

(Signed) Wm F. Schwensberg M. D.

Oct 4 1914, (Address) 130 W Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Oct 6, 1914

20-UNDERTAKER	ADDRESS
Geo Lembeck & Co	647 W Pratt

Spec.—8-24-14—M. & T.—2000 Bks.

D 57418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57418

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital St.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Nora Wyatt

(Residence in Baltimore: No. 41 S. Schroeder St. St.; 21 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Sept 21st, 1900
(Month) (Day) (Year)

7-AGE, 21 yrs. 10 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): work

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Kenny

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Lena O'Brien

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Clarence Wyatt

(Address) 220 N Elwood Ave

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 1, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19 1921, to Oct 1 1921; that I saw her alive on Oct 1 1921, and that death occurred, on the date stated above, at 10.20 P.m.

The CAUSE OF DEATH* was as follows:

Syphilis (+++). - Uterine Infection (Post-Abortional) - Erysipelas - Acute Nephritis - Broncho - Pneumonia (Terminal)

..... (Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Double Broncho-Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) S. L. Johnson M. D.

Oct. 1, 1921 (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 12 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 41 S. Schroeder St

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, St Joseph Cem Texas Md. DATE OF BURIAL, Oct 5 1921.

20-UNDERTAKER J. J. Cowan & Son ADDRESS 901 Hollins St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57419

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 57419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Asquith St.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella E Bull

(Residence in Baltimore: No. 1716 Asquith St St.; 56 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE 81 yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Balto Co Md

PARENTS.

10-NAME OF FATHER. John Mash

11-BIRTHPLACE OF FATHER (State or Country). Balto Co Md

12-MAIDEN NAME OF MOTHER asked + not given

13-BIRTHPLACE OF MOTHER (State or Country). asked not given

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Bull

(Address) 1716 Asquith St

15-

Filed ..... 191.

OCT 4-1921

J Ellis Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1921, to Oct 2 1921, that I saw h.. alive on Oct 2 1921, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) Henry Bruns M. D.

Oct 3, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, St Marys Hampden | DATE OF BURIAL, Oct 6, 1921

20-UNDERTAKER H.S. Marshall 3539 Falls | ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-57420 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57420

CERTIFICATE OF DEATH. 642

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N Port St.: 6 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Zelenka

(a) RESIDENCE. NO. 13 N Port ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Center Zelenka

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 65 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: John Benda

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Emma Tofron

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: William Zelenka
(Address) 2643 E Monument St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Oct 2 1921 that I last saw h[illegible] alive on Oct 2 1921 and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(a) ..... (duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William Hyson M. D.

Oct 3 1921 (Address) 804 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 5 1921
20 UNDERTAKER	ADDRESS
Frank Grace & Son	1916 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57421

109 [redacted]

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 Herrin Ct St.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Gray

(a) RESIDENCE. No. 223 Herrin Ct St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married (Husband)

6 DATE OF BIRTH (month, day, and year): 7/4/1874 ~~1875~~

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~46~~ ~~47~~	47	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Labor. C&O

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont know

12 MAIDEN NAME OF MOTHER: Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont know

14 Informant: Emma Gray

(Address) 223 Herrin Ct.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10 - 2 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-27 ..... 1921, to 10 - 2 - 1921, that I last saw h[illegible] alive on 10 - 1 ..... 1921, and that death occurred, on the date stated above, at 9,15 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

dont know.

CONTRIBUTORY (Secondary) Mitral Insufficiency (duration) ... yrs. ... mos. ... ds.

Cardio Sclerosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W H Cargill, M. D.

10/3/1921 (Address) 611 N Carroll

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Cemetery	oct 4 1921
20 UNDERTAKER	ADDRESS
Rhodes White	113 Wolfe St

TION is very important. See instructions on back of certificates. If may be properly classified. Exact statement of OCCUPA-

GENERAL AFFIDAVIT

THE DAILY RECORD PRINT

State of Maryland, Baltimore City, **to wit:**

BE IT REMEMBERED, That on this 7th day of October,

A. D. 1921, before me, the subscriber, a Notary Public

of the said State, in and for the City aforesaid, personally appeared

Emma Gray, 223 Herring Court,

and made oath in due form of law that she is the widow of William Gray,

who died on October 2nd, 1921, in Baltimore City,

And further makes oath, that the age mentioned in

the Certificate of death, issued by Health Department,

which is 117 years old, should be 45 years,

And further makes oath, that William Gray, was born

on July 4th, 1876, and therefore is 45 years old, instead of

117 years old, as mentioned in the attached Certificate.

All of which is true to the best of her knowledge and belief.

Emma Gray

SWORN AND SUBSCRIBED
TO BEFORE ME THIS
7th DAY OF October 1921

William E. Schul, Notary Public

GENERAL AFFIDAVIT — LUCAS BROS., INC., FORM 56

State of Maryland, Baltimore City, to wit:

BE IT REMEMBERED, *That on this* 5th *day of* October *A. D. 19* 21, *before me, the subscriber, a* Notary Public *of the said State, in and for the City aforesaid, personally appeared* Frank Foster of 2142 S Bethel for Baltimore Md *and made oath in due form of law that* I have known William Gray deceased all my life; and said Gray was only 45 yrs old on July 4th 1921, who was born on October 2nd 1921 and said Gray was born July 4th 1876.

Witness
Geo A Gray

Frank X Foster
mark

Witness my hand Notorial Seal

George A Gray
Notary Public

Spec.—6-9-19—H. P. Co.—1000 Bks.

57422 D 57422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1001 West Baltimore St ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Plack

(a) RESIDENCE. NO. 1001 West Baltimore St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 2nd 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER George Plack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Katherine Kassler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mollie Mansfield
(Address) 1001 W. Baltimore St.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2nd 21

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 . 1921 . to Oct 2nd . 1921 .
that I last saw h[illegible] alive on Oct 2 . 1921 .
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Parenchymatous Nephritis of about 2 yrs duration, & an arterio-sclerosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral effusion.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? U.A. Etc.

10/3 . 1921 (Signed) Bernard S. French, M. D.
(Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Oct 5th 1921
20 UNDERTAKER	ADDRESS
Capsl P. Cook.	1003 N. Pa. Ave St

Spec.—8-24-14—M. & T.—2000 Bks.

57423 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57423

CERTIFICATE OF DEATH. X 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. St.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida E. Stafford

(Residence in Baltimore: No. Bowen, Calvert County. Md. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January (Month) 30 (Day), 1861 (Year)

7-AGE, 60 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 137

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Richard Emrick

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Douglass

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm B. Stafford

(Address) Bowens Md

15-

Filed....., 191.. 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 26 1921, to October 3 1921, that I saw her alive on Oct. 3 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

1 Hypertyroidism

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Thyroid-toxic crisis

4 operations (Duration) ....yrs. ....mos. 3 ds.

(Signed) Louis M. Finko M. D.

Oct. 3, 1921. (Address) Grant. Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State 60 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Air Home

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury M E Church. Calvert Co. DATE OF BURIAL, Oct. 5, 1921.

20-UNDERTAKER W M Routson ADDRESS 2238 N Monta

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57424 D 57424

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4th St. near 2nd Ave, Fairfield 25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mary Herlth

(a) RESIDENCE. No. 4th St. near 2nd Ave. St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 10 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	23	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Infant X DW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George August Herlth

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Winterling

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant George August Herlth
(Address) 4th St. near 2nd Ave Fairfield

15 Filed ..... 19 ... WDA Registrar

4-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1921, to Oct 3, 1921, that I last saw her alive on Oct 3, 1921, and that death occurred, on the date stated above, at 3:10 a.m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions 8 hours
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) Geo B Davis M. D.

Oct 3. 1921 (Address) 21 Church St, Ants. Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Oct 3 1921
20 UNDERTAKER	ADDRESS
J Marguerite Flynn	1422 Argyle St.

(See instructions on back of certificates.)

Spec.—6-9-19—H. P. Co.—1000 Blks.

57425

HEALTH DEPARTMENT—CITY OF BALTIMORE

57425

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Brookes Lane ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon L. Goodman

(a) RESIDENCE. No. 824 Brookes Lane ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Bailey Goodman

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Hans Goodman

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Leah Kline

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Goodman
(Address) 824 Brookes Ln

15 Filed ....., 19 OCT 7 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan ....., 1921, to Oct 3 , 1921,

that I last saw h him alive on Oct 3 , 1921,

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrahms, M. D.

Oct 3, 1921 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Baltimore Hebrew Oct 5 1921

20 UNDERTAKER — ADDRESS

Hart & Sondheim 1180 W Baltimore

Read instructions on back of certificates. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 57426

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 North Broadway, ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph E. Dugent

(a) RESIDENCE. No. 1805 North Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kavanaugh

6 DATE OF BIRTH (month, day, and year) June 25, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Business

(c) Name of employer Cadillac Auto Agency

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Catherine K. Dugent
(Address) 1805 N. Broadway

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to Oct 1, 1921, that I last saw him alive on Oct 1, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Regurgitation not syphilitic (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history & phys. findings

(Signed) Geo M Lear, M. D.

10/3, 1921 (Address) 20 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 3/21 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son,	805 N. Calvert

See instructions on back of certificates. Incomplete application. Incorrect statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

57427

HEALTH DEPARTMENT—CITY OF BALTIMORE

57427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 214 N Mount ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Thompson

(a) RESIDENCE. No. 214 N Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or ~~divorced~~
HUSBAND of (or) WIFE of John Henry Thompson

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ——— 000

(c) Name of employer ———

9 BIRTHPLACE (city or town) Centreville
(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Weeks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Chas Thompson
(Address) 214 N Mount St.

15 Filed Oct 4, 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1921, to Oct 2nd, 1921, that I last saw h[illegible] alive on Oct 1st, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Marks, M. D.

1921 (Address) 901 Mystic

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemty	Oct 5th 1921
20 UNDERTAKER	ADDRESS
John F Owens	538 Dallas St

Instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 57428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57428

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2828 Elliott ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Szeliga

(a) RESIDENCE. No. 2828 Elliott ST., 1 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1883 Mar 3

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bodle Poland

PARENTS

10 NAME OF FATHER John Holewenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John Szeliga

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1921, to October 3, 1921, that I last saw her alive on October 3, 1921, and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:
Extensive burn from chin to knees down, (dress caught on fire while cooking)

(duration) yrs. 7 ds.

CONTRIBUTORY (Secondary) tuberculosis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Januszewski M. D.

19 (Address) 2431 Fait

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 6 19
20 UNDERTAKER	ADDRESS
Stephen J. Fralkowski	1005 S.

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

57429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57429

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Mc Elderry. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. Fridel

(a) RESIDENCE NO. 3107 Mc Elderry. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Fridel

6 DATE OF BIRTH (month, day, and year) Dec 8th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 009

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Line Element Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Fridel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Julia Fridel

(Address) 3107 Mc Elderry St.

15 Filed , 19 M7A. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5 , 1921 , to October 2 , 1921 , that I last saw him alive on October 1 , 1921 , and that death occurred, on the date stated above, at 11.05 a m.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) Albert Colsudberg M. D.

1921 (Address) 2027 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 8 1921
20 UNDERTAKER	ADDRESS
Libby & Zeller	[illegible]

FRONT—IS very important. See instructions on back of certificates. LAST Statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57430

CERTIFICATE OF DEATH.

15 D 57430

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Greene ST.: 4 WARD) 6

2-FULL NAME Baby D Heppard

(a) RESIDENCE. NO. Warren Mds ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1921

7 AGE Years Months Days If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George H Sheppard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Sarah E Brown

13 BIRTHPLACE OF MOTHER (city or town) Warren (State or country) Baltimore Co. Md.

14 Informant Hospital Records
(Address)

15 Filed 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1921, to Oct 4, 1921, that I last saw him alive on Oct 4, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Morris Reese, M. D.

10-4-1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 4 19 21
20 UNDERTAKER	ADDRESS
Harry H. Wiltz	158 W. Lombard St

Check of certificates. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Dr. Wm. A. B. Sellman.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57431 D 57431

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH 2724 N. Charles St

CITY OF BALTIMORE: (No. Biddle & 4 ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Olive Sellman

(Residence in Baltimore: No. The Royal Apartments St.; 17 yrs., 6 mos. 2 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 2, 1849 (Month) (Day) (Year)

7-AGE, 72 yrs. 2 mos. 1 da.

If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE, (State or Country), Elkton Cecil Co. Md

PARENTS.

10-NAME OF FATHER, Thos. V. Olin

11-BIRTHPLACE OF FATHER (State or Country), Massachusetts

12-MAIDEN NAME OF MOTHER Sewall

13-BIRTHPLACE OF MOTHER (State or Country), Cecil Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Wm. A. B. Sellman

(Address) The Royal Apartments

15-

Filed....., 191.....

Registrar.

Robert F. Harrison, 1927 Chief Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3 (Month) (Day) 1921 (Year)

Bay View Hospital 2724 N. Charles St

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1921, to Oct 3 1921, that I saw h.. alive on Oct 2 1921, and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Asthmatic

..... (Duration)...yrs...mos...3...da.

CONTRIBUTORY (Secondary)

Bronchitis (Duration)...1...yrs....mos.....da.

(Signed) W. A. B. Sellman M. D.

Oct. 3, 1921. (Address) 5 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State 64 yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? New York City

Former or usual residence The Royal Apts. Balto. Md

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 5, 1921

20-UNDERTAKER Chas. Divver & Son — ADDRESS 115 N. Howard St

Spec.—6-2-19—H. P. Co.—1000 Bks.

D 57432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57432

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1224 N. Eden St.: 10 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Cook

(a) RESIDENCE. No 1224 N. Eden St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~wife of~~: Grace W. Cook

6 DATE OF BIRTH (month, day, and year): Nov. 15th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Station Master

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. 173

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry A. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia Ohio

12 MAIDEN NAME OF MOTHER: Margaret Kerbill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Grace W. Cook
(Address) 1224 N. Eden St.

15 Filed Oct 7th 1921. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 1921, to Oct 4, 1921, that I last saw him alive on Oct 3, 1921, and that death occurred, on the date stated above, at 1.05 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. J. Gerry, M. D.

(Address) 647 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Oct. 6th 1921
20 UNDERTAKER: Philip Herwig	ADDRESS 206 Orleans St.

A-1921

Burial Permit Clerk.

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57433

HEALTH DEPARTMENT—CITY OF BALTIMORE

78 D 57433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hamilton ave E. of Belair Rd St. 26th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Evans

(a) RESIDENCE NO. East Hamilton Ave ST. 26th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. 10 ds. 16 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth B. (Biddison) Evans

6 DATE OF BIRTH (month, day, and year) Nov. 17-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	60	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raspburg, Balto. Co. Maryland

PARENTS

10 NAME OF FATHER John Christopher Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cath. Ann Froome

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary G. Evans.

(Address) East Hamilton Ave E of Belair Road

15 Filed ... 19 ... Registrar

Robert P. Harrison,

4 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1920 to Oct. 3 1921

that I last saw him alive on Oct. 3 1921

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

(1) Tuberculosis, (1) Laryngeal, and (2) Pulmonary.

(duration) 0 11 yrs. 0 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Wilkinson M. D.

10/4 1921 (Address) 13 Bel Air Road, Raspburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Biddisons Cemetery Sardenville Balto Md

DATE OF BURIAL Oct 6th 1921

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

This is very important. See instructions on back of certificates. FACT statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57434

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3628 Maple Av, West Woodbury ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Schaeffer.

(a) RESIDENCE. No. 3628 Maple Av, West Woodbury ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12 hrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 3228 Maple Av West Woodbury.

PARENTS

10 NAME OF FATHER Norman Hubbs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Fernita Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1921. to Oct. 2, 1921.

that I last saw him alive on Oct 2 1921.

and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity. a 4½ to 5 mos. intra uterus child.

(duration) yrs. mos. 12 hrs.

CONTRIBUTORY (Secondary) Miscarriage.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) N. Clyde Marvel, M. D.

Oct 2, 1921 (Address) 3311 Abell Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

Robert P. Harrison, Burial Permit Clerk.

Commissioner Health.

Note.—Items are very important. See instructions on back of certificates. Exact statement of OCCUPA-

D 57435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57435

CERTIFICATE OF DEATH.

REGISTERED No. C 102

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 407 Cumberland ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Douglas Hampden

(Residence in Baltimore: No. 407 Cumberland St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	?

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE. about 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: artist
(b) General nature of industry, business, or establishment in which employed (or employer): 001

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Police Capt

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

TA-1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Perf ulcer stomach

Hard Rum (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

Hard Rum (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Sept 1, 1921 (Address) 1639 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
PUBLIC CEMETERY	
20-UNDERTAKER	ADDRESS

Important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57436 HEALTH DEPARTMENT—CITY OF BALTIMORE D 574

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.) 10 WARD)

(If death occurr hospital or Inst give its NAME of street and num fill out No. 18.)

2-FULL NAME May Barret

(Residence in Baltimore: No. 819 St Paul St.; yrs., mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 dny, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.?

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Poland Aust

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1
(Month) (Day)

17- I HEREBY CERTIFY, That I took charg remains described above, held an..... Inquest
(Inquest, autopsy or

thereon and from the evidence obtained by said.... (I

Inquest and that said deceased came to... topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Uric Acid Heart

..... (Duration)..... yrs..... mos.

CONTRIBUTORY (Secondary) Kidney

..... (Duration)..... yrs..... mos.

(Signed) Huntley
(Coroner.)

Oct 1, 1914 (Address) 1057 Eu

*State the DISEASE CAUSING DEATH, or, in deaths from VIOL state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, S HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTI SIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. 1½ mos.....ds. In the State.....yrs.....m

Where was disease contracted, if not at place of de

.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY DATE OF

20-UNDERTAKER ADDRESS

OCT 4 191 Robert P. Harrison, Commissioner of Health. Burial Permit Clerk.

Original

D-7436 HEALTH DEPARTMENT—CITY OF BALTIMORE D-7436

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 819 St. Paul St' ST., WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. May Anderson

(Residence in Baltimore: No. 819 St. Paul St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 28 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, — Paddon

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Ann Rice

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Anderson

(Address) 733 W. Lombard

15- Filed OCT 17 1921 191... ROBERT P. FOUTER Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Sudden

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Ruley M. D.
(Coroner.)

Oct 14, 1921. (Address) 1459 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery Catonsville — DATE OF BURIAL, Oct 18, 1921

20-UNDERTAKER John F Denny — ADDRESS 715 Light St

IMPORTANT: CERTIFICATE: PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57437

D 57437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Fremont Ave St.: 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Daniels

(a) RESIDENCE. No. 518 N. Fremont Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert T. Daniels

6 DATE OF BIRTH (month, day, and year) Jan 4th 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia Md

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bankenship

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Joseph H. Daniels 1347 E. Calhoun St

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29th, 1921, to Oct 3rd, 1921, that I last saw her alive on Oct 3rd 10:45 AM 1921, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs and Symptoms

(Signed) C. J. Hammer, M. D.

, 19 (Address) 1429 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct. 5th 1921

20 UNDERTAKER — ADDRESS

Mc & Mc John H. Penfold & Son — 801 W. Fayette St

Instructions on back of certificates. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

57490 a^m

150 11 30 a^m

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 150 D 57438

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane J. Ebbert

(a) RESIDENCE NO. % Gen'l. Electric Birmingham Alabama St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25th 1920

7 AGE — Years: | Months: 14 | Days: 9 | If LESS than 1 day, ...hrs. or .... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Birmingham Alabama

PARENTS

10 NAME OF FATHER Sprigg C. Ebbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER Douglas Julian

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed ....., 19.... Robert F. [illegible] 192[illegible] Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 1921, to Oct 4, 1921,

that I last saw her alive on Oct 4th, 1921,

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

hydrocephalus

(duration) 1 yrs. 2 mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Alabama.

Did an operation precede death? yes Date of Oct. 4, 1921

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Emil Holman M. D.

10-4-21, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Birmingham Alabama

DATE OF BURIAL: 10/4 1921

20 UNDERTAKER: Robert Burkam

ADDRESS: Calhoun Hollins

FROM IS very important. See instructions on back of certificates. EXACT statement of OCCUPA-

(Sawczenko)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57439 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57439

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Sawczenko

(a) RESIDENCE. No. 1419 Grace Court. Canton Bay WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 10 yrs. 0 mos. 0 ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Annie Doris Sawicki

6 DATE OF BIRTH (month, day, and year) April 28. 1892.

7 AGE: Years 29 | Months 5 | Days 10. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car Repairer. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Harry Sawolski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Mary Motowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant Anna Sawicki
(Address) 1419 Grace Court

15 Filed ..... 19 ..... Registrar
ROBERT I. [illegible]
1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from July 23. 1921. to Oct. 3rd. 1921. that I last saw him alive on Oct 3rd. 1921. and that death occurred, on the date stated above, at 8.25 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis. with Abscess

(duration) yrs. 2. mos. 14. ds.

CONTRIBUTORY (Secondary) Fecal Fistulae and Intestinal Obstruction (duration) yrs. 2 mos. 3 ds.

18 Where was disease contracted if not at place of death? 1419 Grace Court. Canton Bay

Did an operation precede death? Yes Date of 7/25/21. 8/30/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) John W. Metcalf, M. D.

10/3/1921 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross, R.C. | DATE OF BURIAL: 10/5 1921

UNDERTAKER: Wm Faelkowski | ADDRESS: 418 Caster

NOTE—It is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D 57440 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57440

CERTIFICATE OF DEATH. 79

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 833 Powers St. ST. 13 WARD)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Alice G. McFadden

(Residence in Baltimore: No. 833 Powers St. St. 24 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) 3 (Day), 1875 (Year)

7-AGE 46 yrs. 6 mos. — ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or Country) Anne Arundle Co. Md.

PARENTS.

10-NAME OF FATHER Louis Fantge

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Virginia Nowell

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas A. McFadden

(Address) 833 Powers St.

15-

Filed ... 191...

Robert P. Harrison,

Burial Permit Clerk. Registrar.

4-1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. (Coroner.)

..., 191... (Address) 3631 Falls Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL/OR REMOVAL, Mt. Olivet — DATE OF BURIAL, Oct. 6, 1921

20-UNDERTAKER Horace H. Burgee — ADDRESS 3631 Falls Rd

Important. See instructions on back of certificate. Last statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57441

CERTIFICATE OF DEATH.

64 D 57441

1-PLACE OF DEATH Howard Park 4812 Hendale ave

CITY OF BALTIMORE: (NO. Ave. ST., 28 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Levinia George

(a) RESIDENCE NO. 4812 Hendale ave ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 94 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Franklin George

6 DATE OF BIRTH (month, day, and year) 2nd Feb. 1827.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
94		8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Shamburg

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Jane Montgomery

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Ireland.

14 Informant Emma G. Choate
(Address) Roslyn — Maryland.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1917 to Oct 3 1924.
that I last saw h alive on Oct 3 1924.
and that death occurred, on the date stated above, at 8.15 P.M.
The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(duration) 3 yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) H. L. Fetter M. D.

10-4 1924 (Address) 2042 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Oct 5 1924
20 UNDERTAKER	ADDRESS
W J Tucker	Govanstown

FROM a very important. See instructions on back of certificates. Exact statement of OCCUPA-

E. P. Harrison,
1924 Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

D57442 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D57442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Elvrin Place ST., 6 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Nelson

(a) RESIDENCE No. 9 Elvrin Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 7 yrs. 6 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE: Years 68; Months —; Days —; If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1411 E Balto St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 10 1921, to Oct 2 1921, that I last saw him alive on Oct 2 1921, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Passive Congestion & dropsy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. S. Hoffman, M. D.

10/4/1921 (Address) 1573 N Bentalou st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer Rosedale — DATE OF BURIAL: 10/5 1921

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balto

FRONT

Very important. See Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57443

CERTIFICATE OF DEATH.

1700 57443

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew Hospital St.: 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Finkelstein

(a) RESIDENCE. No. 1400 N. Gilmor St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Finkelstein

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper 034

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E Balto St

15 Filed OCT 5 – 1921, 19 ..... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1921, to Oct 3, 1921, that I last saw him alive on Oct 3, 1921, and that death occurred, on the date stated above, at 9:15a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

1 day (?) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Gellman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mourning Rm	10/5 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

Sec. 4. Every statement of OCCUPATION is important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57444

CERTIFICATE OF DEATH.

167 D 57444

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Queen

(Residence in Baltimore: No. 1008 Russell Lane St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, ..., 1910
(Month) (Day) (Year)

7-AGE, 11 yrs. mos. ds. If LESS than 1 day, hrs. or mlu.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Boy
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, James Queen

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER May Robinson

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Queen

(Address) 1008 Russell Lane

15-

Filed OCT 5 - 1921, 191.....

ROBERT J. BRAUTER
REGISTRAR OF VITAL STATISTICS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry. find that said deceased came to.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

30 M Burns over Greater part of body by burning gasoline on Bon fire Accident

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jere M Fenton M. D.
(Coroner.)

Oct 3, 1921 (Address) 700 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1008 Russell Lane

Former or usual residence 1008 Russell Lane

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct 5, 1921

20-UNDERTAKER Edward Ruzycki ADDRESS 1463 Hanover St. Balto Md

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. Any other information that may be desired may be given.

D 57445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181 D 57445

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fourth Ave Broadway ST.; Richels Dispensary WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E Shanklin

(Residence in Baltimore: No. 734 S Bond St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Negro	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 23 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) U S

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Frank

(Address) 734 N Bond St

15-

Filed....., 191.....
Registrar.

OCT 5 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally electrocuted

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Lyle Einstein M. D.
(Coroner.)

Oct 5, 1921 (Address) 1600 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Oct 7, 1921
20-UNDERTAKER John E Henderson	ADDRESS 1622 Monument

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57446 — 137 D 57446

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Oliver

(a) RESIDENCE NO. 802 E. St. Paul St., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black.	Married

5a If married, widowed, or divorced (or) WIFE of Tenly Oliver

6 DATE OF BIRTH (month, day, and year) Sept 10 1887

7 AGE Years	Months	Days	If LESS than 1 day, ✗ hrs. or ✗ min.
34	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (?)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Melton Carter

11 BIRTHPLACE OF FATHER (city or town) —(?)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Lucy Knight

13 BIRTHPLACE OF MOTHER (city or town) —(?)
(State or country) Virginia

14 Informant Johns Hopkins Hospital
(Address) Record

15 Filed OCT 5 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1920 to Oct. 4, 1921, that I last saw her alive on Oct 4, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal infection following Ne Partus toxaemia

(duration) — yrs. — mos 12 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) H. C. Cathcart, M. D.

10-4-21, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burks Ville Va

DATE OF BURIAL Oct 4 1921

20 UNDERTAKER John W Henderson

ADDRESS 1305 E Monument

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D 57447 HEALTH DEPARTMENT--CITY OF BALTIMORE D 57447

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Home for the Aged of the M. E. Church St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary E. Shipley.

(Residence in Baltimore: No. S.W. Cor Franklin and Fulton Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: June 28, 1850 (Month) (Day) (Year)

7-AGE: 71 yrs. 3 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Samuel E. Tenyhill

11-BIRTHPLACE OF FATHER (State or country): Calvert Co. Md.

12-MAIDEN NAME OF MOTHER: Ann Eliza Fleming

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Cuddy

(Address) 111 N. Fulton Ave.

15-

Filed OCT 5 1921, 191... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 4, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany. 1, 1921, to Oct 4 1921 that I saw h[illegible] alive on Oct 2d, 1921, and that death occurred, on the date stated above, at 8.45 p m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

(Duration) [illegible] yrs. 9 mos. [illegible] ds

Contributory (SECONDARY) Arterio Sclerosis

(Duration) [illegible] yrs. 4 mos. [illegible] ds.

(Signed) George C. Shannon M. D.

Oct 6. 1921 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Oct 7, 1921

20-UNDERTAKER: George J. Smith — ADDRESS: 1600 Eden St.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57448

45 D 57448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3514 Clifton Ave St.: 15 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine L. Records

(a) RESIDENCE. No. 3514 Clifton Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Records

6 DATE OF BIRTH (month, day, and year) June 25 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D. C.
(State or country)

PARENTS

10 NAME OF FATHER Franklin Gardner

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Finley

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Rachel L. Paton
(Address) 3517 Clifton Ave

15 Filed OCT 5 — 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9th, 1921, to Oct 6th, 1921, that I last saw her alive on October 3d, 1921, and that death occurred, on the date stated above, at 7 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Epithelioma of the foot, left, above and between the 4th and 5 toes

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

Anemia (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? Radium Date of Aug 10/21

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) John D Pennington, M. D.

19 (Address) 1826 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 6 1921
20 UNDERTAKER	ADDRESS
J D Mitchell	1221 W Fayette St

Instructions: Please write plainly. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See Nomenclature and Physicians' Classified List of Causes of Death on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

A 57449 — 170 D 57449 — REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 507 Gittings (St.) 24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C Wentworth

(a) RESIDENCE. No. 567 Gittings St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie R Wentworth

6 DATE OF BIRTH (month, day, and year) Sept 4 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	—	28	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Thomas T Wentworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah A Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Minnie R Wentworth
(Address) 507 E Gittings st

15 Filed OCT 5 19— 1921 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 19 21, to Oct 1, 1921, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Bright's disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) F. Edw. Smith M. D.

10/4 1921 (Address) 910 Light st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 5 1921

20 UNDERTAKER John F Denny — ADDRESS 715 Light

Burial permit issued

Instructions: See instructions on back of certificates. Last statement of OCCUPA-

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57458

CERTIFICATE OF DEATH.

1 59 D 57450

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Court House. St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Zelisse.

(Residence in Baltimore: No. Hickory Ave Overlea St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 15, 1880
(Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066

9-BIRTHPLACE, (State or Country), East India.

PARENTS.

10-NAME OF FATHER, John Zelisse.

11-BIRTHPLACE OF FATHER (State or Country), Holland

12-MAIDEN NAME OF MOTHER Dont Know.

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johanna Zelisse

(Address) Overlea

15-

Filed ..... 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach Cancer

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 5 1921 (Address) 1654 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, Oct 5, 1921.

20-UNDERTAKER Wm Cook

ADDRESS 602 E. Fayette.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 57451 — CERTIFICATE OF DEATH — 154 — D 57451

1-PLACE OF DEATH — Registered No. C .....

CITY OF BALTIMORE (No. 1008 Lindenar St.: W Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. McElroy

(Residence in Baltimore: No. 1008 Lindenar St.: 68 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ..... (Month) 1853, 1 (Day) (Year)

7-AGE: 68 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cutler Maker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: John C McElroy

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Mary J. Kirkpatrick

13-BIRTHPLACE OF MOTHER (State or country): Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. B. Bawerman

(Address) 15 W 27th St

15-

Filed — — 1921 ROBERT I. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 4 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1921, to Oct 4 1921 that I saw him alive on Oct 3 1921 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pre-Senile decay.
(Senile Dimentia)
(Duration) ..... yrs. ..... mos. ..... ds
Refusal to eat (Starvation)
Contributory (SECONDARY)
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. M. McDonald M. D.

10-5-21, 191 (Address) 1323 Park ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Balto Cent | DATE OF BURIAL: Oct 6, 191

20-UNDERTAKER: Wm Cook | ADDRESS: 502 E Monument ave

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should be filled EXACTLY.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57452

CERTIFICATE OF DEATH.

D 57452

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Druid Hill av. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter L. Larkins

(Residence in Baltimore: No. 1235 Druid Hill av. St.: 22 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH. May 27, 1899. (Month) (Day) (Year)

7-AGE. 22 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer): 886

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, George H. Larkins

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Minnie E. Douglas

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. Larkins

(Address) 1225 Druid Hill Ave

15-

ROBERT J. KRAUTER

OCT 5 1921

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1921, to Oct. 3 1921, that I saw him alive on Oct. 2 1921, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about one year

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. M. Cook M. D.

Oct 3, 1921. (Address) 1107 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn. DATE OF BURIAL, Oct 5, 1921.

20-UNDERTAKER, Sam'l H. Close & Son. ADDRESS 1400 Mosher

57453

HEALTH DEPARTMENT—CITY OF BALTIMORE

57453

CERTIFICATE OF DEATH.

64

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 911 N. Vincent ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Sims

(Residence in Baltimore: No. 911 N. Vincent St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): single

6-DATE OF BIRTH, ... (Month) ..... (Day), 1887 (Year)

7-AGE, 44 yrs. ..... mon. ..... ds.

If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work,
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Perry Carter

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER M. A. Murry

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augustus Mims

(Address) 419 N. Bruce St.

15-

Filed OCT 5-1921, 191 ..... ROBERT J. BRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Heuisler M. D. (Coroner.)

Oct. 4, 1921 (Address) 2502 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct. 1921

20-UNDERTAKER Wm. W. Chase Sons — ADDRESS 1400 Mosher St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

D 57454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57454

CERTIFICATE OF DEATH.

170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2632 Greenmount Ave ST., 9 WARD)

2-FULL NAME Mary C. O'Neill

(a) RESIDENCE NO. 2633 Greenmount Ave ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced (HUSBAND of) (or) WIFE of Joseph C. O'Neill

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	68	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Abt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Anna Reilly

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs Anna Brewer

(Address) 2633 Greenmount Ave

15 Filed OCT 5 — 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921, to Oct 4th, 1921, that I last saw her alive on Oct 4th, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) ? yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Physical Exam

(Signed) Geo Klingenberg M D, M. D.

10/4/1921 (Address) 4016 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct. 7 1921
20 UNDERTAKER	ADDRESS
Henry Adock Son	1501 E Eager

IMPORTANT is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57455

CERTIFICATE OF DEATH.

D 57455

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Peach alley WARD 73)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Elkins,

(a) RESIDENCE. No. 915 Peach alley ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sydnie Elkins

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 140

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer unemployed

9 BIRTHPLACE (city or town) (State or country) Alexandria Live in Balt 30 yrs. Va.

PARENTS

10 NAME OF FATHER Harris Elkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Jains

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Georgia Elkins (Address) 923 S Charles

15 Filed ....., 19 ..... Registrar

OCT 5—1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1st 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 30 . 1921 . to Oct. 1st . 1921 .

that I last saw h alive on Oct. 1st . 1921 .

and that death occurred, on the date stated above, at 4, P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy with Effusion (Left side) (Chronic)

about 2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Appearance of chest

(Signed) D. J. Kennedy, M. D.

10/4/1921 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Oct 5 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1726 Pennsylvania Ave

OCT 5—1921

Important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57456

D 57456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Somerset ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virgie E. Jackson

(a) RESIDENCE. NO. 422 Somerset ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Servant 070

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas P. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ida Procter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Chas P. Jackson
(Address) 422 Somerset St

15 Filed OCT 5 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1921, to Oct 2, 1921, that I last saw h[illegible] alive on Oct 2, 1921, and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Fistula of Rectum.
Th of bowels.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of Apr 1921
No.

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) A. H. Hinkelbein, M. D.

10/3, 1921 (Address) 733 Arsenault St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 6 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1735 Ashland Av

Important. See instructions on back of certificates. Read statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57457

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View St. 3 WARD)

REGISTERED No. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Scott

(a) RESIDENCE. No. 506 S. Spring St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Live in Balt-15 years Virginia

PARENTS

10 NAME OF FATHER Joseph Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records,
(Address) New City Hospital

15 Filed OCT 5 1921 BUREAU OF VITAL STATISTICS Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1921, to October 3, 1921, that I last saw him alive on October 3, 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

10/4/1921 Address New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct 5- 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725- Ashland Av

Important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

16 1034 57458

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57458

CERTIFICATE OF DEATH. X 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Hunter

(a) RESIDENCE NO. Harford Road ST., Glenarm, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	B.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-17-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ~~000~~

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia Md

12 MAIDEN NAME OF MOTHER Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) L. H. H. Records

15 Filed OCT 5 — 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4th 1921

17

I HEREBY CERTIFY, That I attended deceased from September 30, 1921, to October 4th, 1921,

that I last saw her alive on Oct 4th, 1921,

and that death occurred, on the date stated above, at 3.25 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horace G. Stewart M. D.

10/4. 1921 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct-5-1921
20 UNDERTAKER Mrs. H. A. Elliott	19 ADDRESS 17 N Oakland Av

TION IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

Year a Zero ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57459 ~~D 57459~~ 20 D 57459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. 3 WARD)

2-FULL NAME Louise Zero? Zero

(a) RESIDENCE NO. 806 E. Pratt Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Cb	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant L. H. H. Kendall (Address)

15 Filed OCT 5 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3 1921

17

I HEREBY CERTIFY, That I attended deceased from August 21st 1921 to Oct. 3rd 1921.

that I last saw h[illegible] alive on Oct. 3rd 1921.

and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis, fibrinous, with abscess formation, Septicemia, Streptococcus mucosus

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 21, 21

Was there an autopsy? yes

What test confirmed diagnosis? Blood culture, Operation Autopsy

(Signed) Julian D. Hart M. D.

10-4-21, 19 (Address) Johns Hopkins Hosp. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Asm	Oct 6, 1921
20 UNDERTAKER	ADDRESS
Kendall & Lippert & Son	37 S Amity

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

D 57460

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

X 56

D 57460

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 704 n Ensor St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Perry

(Residence in Baltimore: No. (Blair md) St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, (Month) Dec (Day) 1 (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 140

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Archer

(Address) Towson Md

15-

Filed OCT 5 - 1921 ROBERT P. STARTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Kirby Smith M. D.
(Coroner)

10-5, 1921 (Address) Towson Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Belair Md.	Oct 5, 1921
20-UNDERTAKER	ADDRESS
E & B Hasle	115 E West St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 57461

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 S. East Ave ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Orzech

(a) RESIDENCE. No. 1013 S. East Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	3	4	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work —

(h) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis E. Orzech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ellen Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Louis E. Orzech
(Address) 1013 S. East Ave.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1921, to Sept. 30, 1921, that I last saw him alive on Sept. 30, 1921, and that death occurred, on the date stated above, at 7 15 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry B. Fahey, M. D.

1925. 1921. (Address) 2506 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	Oct 6 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager St.

THIS is very important. See instructions on back of certificates. LARE statement of OCCUPA-

D 57462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57462

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Wale

(Residence in Baltimore: No. 828 Cloy st St. 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Dont Know (Month) 1 (Day) (Year)

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). N Carolina

PARENTS.

10-NAME OF FATHER. Benj Markel

11-BIRTHPLACE OF FATHER (State or Country). N C.

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). N C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Wale

(Address) 828 Cloy st

15-

Filed ....., 191.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct (Month) 1 (Day), 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy or inquiry~~) thereon and from the evidence obtained by said (Inquest, ~~autopsy or inquiry~~) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on her body

(Duration) hr. min. a few hours

CONTRIBUTORY (Secondary) Set on fire by a lighted coal oil lamp thrown by Gilbert

(Duration) yrs. mos. d. a few hours

(Signed) W K Ferguson M. D.
(Coroner.)

10-4, 192 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Oct 5, 1921
20-UNDERTAKER	ADDRESS
Brown & Ireland	114 N Schroeder st

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very necessary. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57463

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Simms Butler

(a) RESIDENCE. No. 1560 Woodyear st. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Butler

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records M.T.H.

15 Filed 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1921, to Oct. 3, 1921, that I last saw her alive on Oct. 2, 1921, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dadaglacen M. D.

10-3-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	oct 6 1921
20 UNDERTAKER	ADDRESS
R & Gross	1405 McElderry

Keep this Certificate clean, dry and unmutilated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57464

CERTIFICATE OF DEATH.

45 D 57464

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 - 3rd Ave. Wagners Pt. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kajdasz

(a) RESIDENCE. No. 114 3rd Ave. Wagners Pt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Petronela Kajdasz.

6 DATE OF BIRTH (month, day, and year) Nov. 29-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Can factory

(c) Name of employer Martin Wagner Co.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Lukasz Kajdasz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Petronela Kajdasz. (Address) 114 3d Ave.

15 Filed ....., 19.... Robert P. Harrison, Registrar

~~1921~~ Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1920, to Oct 4, 1921, that I last saw h[illegible] alive on Sept 24, 1921, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Epithelioma of foot

3 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo 13 Davis M. D.

9/4, 1921 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Oct. 6 1921
UNDERTAKER Wm F. Hallowell	ADDRESS 1618 Eastern Ave.

Note.—Items are very important. See instructions on back of certificates. Exact statement of OCCUPATION is properly classified.

D 57465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57465

CERTIFICATE OF DEATH.

X 119

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Maryland General Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel S. DeVett

(Residence in Baltimore: No. Hotel Caswell St.: yrs., about 0 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Divorced

6-DATE OF BIRTH, About – (Month) (Day), 1876 (Year)

7-AGE, About 45 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman for the
(b) General nature of industry, business, or establishment in which employed (or employer): General Gas Light Co of N.Y.

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Samuel DeVett

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER could not ascertain

13-BIRTHPLACE OF MOTHER (State or Country), Could not ascertain

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Via 'phone message from his

(Address) N.Y. place of Employment.

15- Robert P. Harrison, M. D.

Filed ..... 191.....

OCT 5 - 1921 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute nephritis Hodgkins of lungs 6 wks (Duration) yrs. mos. dd.

CONTRIBUTORY (Secondary) ac. Alcoholism (Duration) yrs. mos. 4 ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Oct. 5, 1921. (Address) 2822 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 1 ds. In the State 0 yrs. 0 mos. 14 ds.

Where was disease contracted, if not at place of death? Baltimore.

Former or usual residence 774 De Salles St. Brooklyn N.Y.

19-PLACE OF BURIAL OR REMOVAL, Brooklyn N.Y. DATE OF BURIAL, Oct 5, 1921.

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, [redacted]) ADDRESS 108 W. NORTH AVE.

important. See instructions on back of certificate.

...properly classified. Exact statement of OCCUPATION is very ...public ...ems, so that it may be properly ...PHYSICIANS should state

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57466

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 11 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Martha Wolfe,

(a) RESIDENCE. No. 623 St. Paul St., Ward. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? Life — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 080

(b) General nature of industry, business, or establishment in which employed (or employer) nnn

(c) Name of employer nnn

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Alonzo Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Martha Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Reeds Mem Hospital Baltimore

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14 1921, to Oct 4 1921,

that I last saw her alive on Oct 4 1921,

and that death occurred, on the date stated above, at 12:45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of colon.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Gone within the

Date of

Was there an autopsy? last year

What test confirmed diagnosis? Finding of tumor & symptoms

(Signed) John Leary, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	10/6/1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, [illegible])	ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be of property classified.

D 57467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57467

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 204 Rook st ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Henry

(Residence in Baltimore: No. 204 Rook st St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Don't Know, 1 (Month) (Day) (Year)

7-AGE: 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: David G. Henry

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Henry

(Address) 204 Rook st

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

OCT 5 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

10-5 1921 (Address) 117 N. Gay st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cambridge Md. DATE OF BURIAL, Oct 6 1921

20-UNDERTAKER: Jas. M. Skinner ADDRESS 1625 E. Monument st

Important. See instructions on back of certificate. ... properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57468

D 57468

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 East Fort Ave. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A Finglas

(a) RESIDENCE. No. 627 E. Fort Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clara Finglas

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Finglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Clara Finglas
(Address) 627 E Fort Ave

15 Filed OCT 6-1921 16 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1921, to Oct 3-21, 19 21,
that I last saw h.um alive on Oct 3-21, 19,
and that death occurred, on the date stated above, at 2:P m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Valvular

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. E. Burton, M. D.

Oct 4, 1921 (Address) 201 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	10/6/1921
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1318 Light St

THIS IS very important. See instructions on back of certificates. EXACT statement of OCCUPA-

Winnie Young

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57469

CERTIFICATE OF DEATH.

29

D 57469

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 720 n Central ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winnie young

(Residence in Baltimore: No. 720 n Central ave St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. 2 0 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House Wife 37
(b) General nature of industry, business, or establishment in which employed (or employer) ..... House Wife

9-BIRTHPLACE. (State or Country), Lie in Balt- S Car Greenville S C.

PARENTS.

10-NAME OF FATHER, Edie Walker

11-BIRTHPLACE OF FATHER (State or Country), S. C

12-MAIDEN NAME OF MOTHER Salie Bocklin

13-BIRTHPLACE OF MOTHER (State or Country), S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Catlins

(Address) 723 N Central Ave

15- OCT 6-1921 Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 4, 191.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm H Smelley M. D.
(Coroner.)

10-4-, 1921 (Address) 4 S Eut

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, Oct 6, 1921.

20-UNDERTAKER Wm Robert A Elliott — ADDRESS 1725 Eutaw

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57470

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 154 N. Kenwood Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara A. Helzer

(a) RESIDENCE. No. 154 N. Kenwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of: Frank A. Helzer

6 DATE OF BIRTH (month, day, and year): Dec. 20th 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
50	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jacob Kaufmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Barbara Graff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Snugerman
(Address) 154 N. Kenwood Ave.

15 Filed: OCT 6 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 2- 1921, to Oct 5- 1921, that I last saw h[er] alive on Oct 4, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Pessagno, M. D.

Oct 8- 1921 (Address) 2314 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem-	Oct. 8th 1921
20 UNDERTAKER	ADDRESS
Philip Herwig	Orleans St.

IION is very important. See instructions on back of certificates. ...ay be properly classified. Exact statement of OCCUPA-

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 57471

CERTIFICATE OF DEATH.

1) 57471

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1408 Rutter St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie J Lomas

(Residence in Baltimore: No. 1408 Rutter St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	widow

6-DATE OF BIRTH, ... (Month) Unknown (Day) ..., 1852 (Year)

7-AGE	If LESS than 1 day,
69 yrs. ... mos. ... ds.	... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Jos. J. Lomas

(Address) 1408 Rutter St.

15-

OCT 6-

Filed ..... 191 .....

BOARD OF HEALTH

Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October 3, ... 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. ... mos. ... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Oct 5, 1921 (Address) 202 Eutaw ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Oct 6th, 1921.
20-UNDERTAKER	ADDRESS
David Carter	916 Eutaw ave.

PHYSICIANS should state DISEASE OR CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Doris A. Scott

HEALTH DEPARTMENT—CITY OF BALTIMORE

57472 D 57472

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 102 Valley Stream Ave Govans ST.; 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris A Scott

(Residence in Baltimore: No. 102 Valley Stream Ave St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 15, 1921 (Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Roy C. Scott

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Anna M Donnally

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy C. Scott

(Address) 102 Valley Stream Ave

15-

Filed OCT 6-1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1921, to Oct 5 1921, that I saw her alive on Oct 5 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Invanition & Ileo Colitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D.

Oct 5, 1921 (Address) 4706 Hopkins Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill DATE OF BURIAL, Oct 6, 1921

20-UNDERTAKER Robt S. Little ADDRESS 2708 Edmondson

Give instructions on back of certificate. Cause of death must be stated. Name of OCCUPATION is very

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57473

CERTIFICATE OF DEATH.

170 D 57473

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James Simmons

(Residence in Baltimore: No. 100 n Front st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Wht.	?

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St.

15-

Filed OCT 6-1921, 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis Mitral

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. C. Conley M. D.
(Coroner.)

9-30, 1921 (Address) 7 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mehren Hessing Bur	10/6, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

IMPORTANT: PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57474

CERTIFICATE OF DEATH.

28 D 57474

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 N. Mount St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Anita Harper

(Residence in Baltimore: No. 522 N. Mount St.; 18 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 22, 1903
(Month) (Day) (Year)

7-AGE, 18 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waitress
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Harper

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co Md

12-MAIDEN NAME OF MOTHER Mary Handy

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Harper

(Address) 522 N. Mount St.

15-

Filed....., 191.....
Registrar.

OCT 6 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1921, to October 5 1921, that I saw h[er] alive on Oct. 5 1921, and that death occurred, on the date stated above, at 8.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

(Signed) T. S. Daugherty M. D.

Oct. 6, 1921 (Address) 1602 Pennsylvania Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Oakland | DATE OF BURIAL, Oct 7, 1921

20-UNDERTAKER John H. Clause Bal | ADDRESS 1401 Mad

Instructions on back of certificate. Space left of OCCUPATION is very

Waddy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57475

CERTIFICATE OF DEATH.

79

D 57475

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1505 E. Preston St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella E. Waddy

(Residence in Baltimore: No. 1505 Preston St. 8 yr.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, Dec 25, 1870
(Month) (Day) (Year)

7-AGE, 51 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm H Pugh

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Adia Y Gary

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Pugh

(Address) 618 S 28th St

15- OCT 6-1921 ROBERT J. KRAUTER Health Commissioner

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cystoma Ovarii Malignant

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank Turney M. D.
(Coroner.)

10-4, 1921. (Address) 29 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dr Lans Cemetery

DATE OF BURIAL, Oct 6, 1921

20-UNDERTAKER Chas J Kenney for

ADDRESS 1442 Park Ave

important. See instructions on back of certificate.

Jos. H. Summers

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57476

CERTIFICATE OF DEATH.

64 D 57476

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1510 n Caroline St. 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Summers

(Residence in Baltimore: No. 1510 n Caroline St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE 72 yrs. mos. ds. If LESS than 1 day, hrs. or 1016 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Hardwood & Mill
(b) General nature of industry, business, or establishment in which employed (or employer) Work Business

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace A. Summers

(Address) 1510 N. Caroline St.

15-

Filed ....., 191.... Registrar.

OCT 6 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 4, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Oct 7, 1921

20-UNDERTAKER Chas. Braun & Son ADDRESS Mount Royal Ave

important. See instructions on back of certificate.

Rose Phillips

D 57477 HEALTH DEPARTMENT—CITY OF BALTIMORE 155 D 57477

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Franklin St Hospital St.: 70 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Phillips

(Residence in Baltimore: No. 2015 Booth St.: (yrs., 17) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse wife
(b) General nature of industry, business, or establishment in which employed (or employer): at home 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Sherman Phillips

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Laura Lindsey

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sherman Phillips

(Address) Mt Airy Md

15-

Filed OCT 6 - 1921, 191 ..... Registrar.

Burial rem...

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute nephritis

..... (Duration) 1 yrs. mos. 3 ds.

(Signed) James M Kemler M. D.
(Coroner.)

Oct 6 1921 (Address) 720 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Prospect Cem Woodlawn Co	10-7-, 1921
20-UNDERTAKER	ADDRESS
Et B Hake	115 E West St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57478

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 E. Monument St.; 11 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Magdalene Hill

(Residence in Baltimore: No. 411 E. Monument St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Sept. 10th, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 25 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Mark S. Hill

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Jane Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Hill

(Address) 411 E. Monument St.

15- Filed OCT 6-1921, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5th, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10th 1921, to Oct. 5th 1921, that I saw h— alive on Oct. 4th 1921 and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

(a) Premature Birth

(b) Mouth Contusions

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Tetanus

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Lee Ellis M. D.

Oct. 5, 1921, (Address) 22 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL, —

DATE OF BURIAL, ..., 191...

20-UNDERTAKER —

ADDRESS —

ROBERT F. KRAUTER, JOHNS HOPKINS HOSPITAL

Commissioner of Health.

OCT 6 1921

Rec. Wm. E. WOODALL

Last statement of OCCUPATION is very

Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57479

D 57479 CERTIFICATE OF DEATH.

152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 817 Rutland Ave (St.) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gilliam

(a) RESIDENCE. No. 817 Rutland Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 817 Rutland Ave Baltimore, Md.

PARENTS

10 NAME OF FATHER James Gilliam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Pocahontas Slipscomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant H. Cathcall M.D.
(Address) Johns Hopkins Hospital

15 Filed OCT 6 - 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1921, to Oct 2, 1921, that I last saw her alive on Oct 2, 1921, and that death occurred, on the date stated above, at 11.00 p.m.

The CAUSE OF DEATH* was as follows:

Atelectasis (Congenital)

(duration) ✓ yrs. ✓ mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Cathcall M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

OCT 5 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57480

HEALTH DEPARTMENT—CITY OF BALTIMORE

175-004

D 57480

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 7S.)

2-FULL NAME Ruth Wilson

(Residence in Baltimore: No. 855 W. Fayette St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH. Oct (Month) 15 (Day), 1918 (Year)

7-AGE.	If LESS than 1 day,
3 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Thomas Wilson

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Anna Patrick

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Patrick

(Address) 855 W. Fayette St

15-

Filed ..... 191... By A. ....., Registrar.

OCT 6-1921 ENTRY 1 PAGE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy or inquiry~~) thereon and from the evidence obtained by said (Inquest, ~~au~~ ~~topsy or inquiry.~~) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest & Pelvis a few mins

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by United S.R. Car- a few mins

(Duration) yrs. mos. ds.

(Signed) H. L. Gorsuch M. D.

(Coroner.)

10-6, 1921 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 7, 1921

20-UNDERTAKER J. Fen McCully — ADDRESS 130 E. Fort Ave.

IMPORTANT. See instructions on back of certificate. PHYSICIANS should state CAUSE OF DEATH CLEARLY. Exact statement of OCCUPATION is very important, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 E. Ostend St. 24, 20 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Valentine

(a) RESIDENCE. No. 113 E. Ostend St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stripper 096

(b) General nature of Industry, business, or establishment in which employed (or employer) Paper Box Factory

(c) Name of employer J. E. Smith Co -

9 BIRTHPLACE (city or town) Leesboro
(State or country) Va

PARENTS

10 NAME OF FATHER Chas. H. Valentine

11 BIRTHPLACE OF FATHER (city or town) Leesboro
(State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Hamilton

13 BIRTHPLACE OF MOTHER (city or town) Leesboro
(State or country) Va -

14 Informant (Address) C. H. Valentine 1132 Ostend St

15 Filed 6-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-1921

17 I HEREBY CERTIFY, That I attended deceased from 9/20/21, 19.., to 10/4, 1921, that I last saw h[illegible] alive on 10/4, 1921, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia (Hypostatic)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic nephritis
Chronic Endocarditis Chronic Myocard[illegible]

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) James A Brown M. D.

. 19.. (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 7 1921
UNDERTAKER	ADDRESS
Mrs J. E. Evans	1428 E. Chas

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Varina

(a) RESIDENCE. No. 621 So. Fremont ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8-1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2.	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. md.

PARENTS

10 NAME OF FATHER: Richard Varina

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. md

12 MAIDEN NAME OF MOTHER: Helen Stauffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. md.

14 Informant (Address): Mr. Richard Varina 621 S. Fremont Ave

15 Filed 1921 Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1921, to Oct 5 1921, that I last saw her alive on Oct 5, 1921, and that death occurred, on the date stated above, at 3 PM m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar + pharyngeal.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) Bella Lovaas, M. D.

Oct 6 1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 6 1921

20 UNDERTAKER: Jos Joerdens + Son

ADDRESS: 217 S Paca St

TION is very important. See instructions on back of certificates. ...may be properly classified. Exact statement of ...CUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 57483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST., 30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Burke

(a) RESIDENCE NO. U.S. Public Health Hosp. #56 ST., 30 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar

(Address) U.S. PHS Hosp. #56 Balto, Md.

15 Filed . 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4, , 1921 , to Oct. 5, , 1921 .

that I last saw h im alive on Oct. 5, , 1921

and that death occurred, on the date stated above, at 7'30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine

March 4, /21 (duration) --yrs. --mos. --ds.

CONTRIBUTORY (Secondary) Nephritis chronic interstitial

(duration) --yrs. --mos. --ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? Yes

What test confirmed diagnosis? Clinic Report

(Signed) Thomas P. Boyle M. D.
Senior Surgeon (R)

10/5, 1921 (Address) U.S. PHS Hosp. #56 Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester Pa

DATE OF BURIAL Oct 6 1921

20 UNDERTAKER Sol Harrison

ADDRESS 1127 E. Balto

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57484

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3418 Cedar Ave ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Danial Swift Paige

(a) RESIDENCE. No. 3418 Ceder Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Paige

6 DATE OF BIRTH (month, day, and year): Oct 4th 1843

7 AGE — Years: 78 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lancaster Pa.

PARENTS

10 NAME OF FATHER: Daniel Patrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lancaster Pa

12 MAIDEN NAME OF MOTHER: Liza Gault

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Manchester

14 Informant: E. D. Paige

(Address): Linthicum Heights

15 Filed , 19

Robert P. Harrison,
Registrar

1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5th 1921

17

I HEREBY CERTIFY, That I attended deceased from July, 1920, to October 4th, 1921, that I last saw him alive on October 4th, 1921, and that death occurred, on the date stated above, at 11.20 A.m.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate

(duration) 1 yrs. 3 mos. ? ds.

CONTRIBUTORY (Secondary): General Carcinosis Peritonei

(duration) 1 yrs. 6 mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of About 1 Yr ago

Was there an autopsy? no

What test confirmed diagnosis? Operation (no microscopic test)

(Signed) William F. Clopton, M. D.

10/5, 1921 (Address) 2919 Huntington Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 10-7th 1921

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun & Mulberry Sts

ATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57485

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 57485

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 N Monroe ST. 16 WARD)

2-FULL NAME Hugh H Jones

(a) RESIDENCE NO. 728 N Monroe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche M Jones

6 DATE OF BIRTH (month, day, and year) Jan 19/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Jones

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Martha Truman

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Blanche M Jones
(Address) 728 N Monroe St

15 Filed ....., 19 ..... Registrar

1921 Robert P. Harris

Shares 3300 W North Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4, 1921

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1919, to October 4, 1921, that I last saw him alive on October 3, 1921, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis &
Chronic myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shannon, M. D.

10/6, 1921 (Address) 3300 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet | DATE OF BURIAL Oct 7 1921

20 UNDERTAKER Wm Lee 502 Nadia | ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57486

CERTIFICATE OF DEATH.

19 D 57486

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N. Fulton Ave St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Agnes Green

(Residence in Baltimore: No. 205 N. Fulton Ave St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, ... Feb. (Month) ..... 5 (Day), 1844 (Year)

7-AGE, 77 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Moore

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Loubiron

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph E. Green

(Address) 205 N. Fulton Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct. (Month) ..... 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Oct 5 1921, that I saw h[illegible] alive on Oct 5 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis and Chronic Myocarditis

..... (Duration) 0 yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry L. Dillon M. D.

Oct 5, 1921. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 8, 1921

20-UNDERTAKER William Cook — ADDRESS 502 E. South Ave

1921 Burial Permit Clerk.

Robert P. Harrison

Cut on this line and paste on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57487

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1031 N^th Fulton ST.: 16 WARD)

2-FULL NAME John Richard Geoghegan

(a) RESIDENCE. NO. 1031 N^th Fulton ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Geoghegan

6 DATE OF BIRTH (month, day, and year) Oct 8 - 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stuart Geoghegan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mont Pillow.

12 MAIDEN NAME OF MOTHER Elizabeth Tschman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mont Pillow

14 Informant Sarah A. Ringer

(Address) 1031 N. Fulton Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1921, to Oct 5 1921, that I last saw him alive on Oct 4 1921, and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH* was as follows:

Chron. Nephritis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Cystitis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) Chas. C. Conser, M. D.

10/5 1921 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 8 1921
20 UNDERTAKER William Cook	ADDRESS 502 North Ave.

Robert F. Carlson
5-1921 Burial Permit Clerk.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Bethin).

D 57488 HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 57488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Wicomico ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bethke

(a) RESIDENCE. No. 1143 Wicomico ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard F Bethke

6 DATE OF BIRTH (month, day, and year): May 10 1900

7 AGE — Years: 21. Months: 4 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): home duties

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Orange. Connecticut

PARENTS

10 NAME OF FATHER: Arthur Potter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Orange. Connecticut

12 MAIDEN NAME OF MOTHER: Kath. Winters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Connecticut

14 Informant: Bernard F. Bethke

(Address): 1142 W. Lanvale St.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Registrar

-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct - 5 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct - 1 1921. to Oct - 5 1921

that I last saw her alive on Oct - 4 1921.

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H G Zinlinger, M. D.

10/6 1921 (Address) 682 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 8 1921
20 UNDERTAKER	ADDRESS
Mullan Cook	502 E Nash

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57489 — CERTIFICATE OF DEATH. — 57 — D 57489

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 852 Columbia Ave St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Edwd. Whalen

(Residence in Baltimore: No. 852 Columbia ave St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) [redacted]

6-DATE OF BIRTH, Dec. 4, 1855 (Month) (Day) (Year)

7-AGE, 66 yrs. 10 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carriage Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 050

9-BIRTHPLACE, (State or Country) Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Steven L. Whalen

11-BIRTHPLACE OF FATHER (State or Country) Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Osborne

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earnest M. Adams

(Address) 1617 W. Balto. St.

15-

Filed ....., 191.... Registrar.

Robert P. Harrison
6-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11th 1921, to Oct. 5th 1921, that I saw him alive on Oct. 4th 1921, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as followa:

Chronic Lead Poisoning
Contracted through his Occupation
as Carriage Painter — 6

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. L. Mackey M. D.

Oct. 5, 1921. (Address) 130 S. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Oct 7, 1921

20-UNDERTAKER Mullain Cook — ADDRESS 502 E. North

Directions on back of certificate.

Occupation of Occupation very

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPART[illegible]ITY OF BALTIMORE

D 57490 BERT HITE

CERTIFICATE OF DEATH.

X 45

D 57490

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME BERT H. HITE

(a) RESIDENCE NO. 322 Pleasant St Morgantown W. Va. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Hite

6 DATE OF BIRTH (month, day, and year) August 18, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	55	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 026

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Isaac Hite

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Katharine Kennen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Hosp. Records

15 Filed ....., 19 Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1921, to Oct 6, 1921, that I last saw him alive on ~~Sept~~ Oct 6, 1921, and that death occurred, on the date stated above, at 11 50 A. m.

The CAUSE OF DEATH* was as follows:

Multiple Myelomata

DDN

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-26-21

Was there an autopsy? Yes

What test confirmed diagnosis? Histological exam.

(Signed) John L. Dorsey, M. D.

10-6-21 . 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgantown W. Virginia — DATE OF BURIAL: Oct 7 19 21

20 UNDERTAKER: Gm. Weber & Son — ADDRESS: 2503 Edmondson Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified. ...state ...so that it ma...

Spec.—1-10-21—M&T—1500 Bks.

D 57491

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57491

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Field ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Aylsworth

(a) RESIDENCE NO. 721 Field ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	✓	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 100

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Ira Aylsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amy Hood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ira Aylesworth

(Address) 721 Field St

15 Filed , 19 Registrar

6-1921 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1921, to Oct 5, 1921,

that I last saw her alive on Oct. 5, 1921

and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute gastritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Fecal Vomiting Purging

(Signed) C. F Coughlin, M. D.

10-5-1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 7 1921
20 UNDERTAKER	ADDRESS
Ebenezer Lee	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15V D 57492

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Wagner alley ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Johnson.

(a) RESIDENCE. No. 1015 Wagner alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept. 24-1921

7 AGE: Years — Months — Days 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — ooo

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Maryland

PARENTS

10 NAME OF FATHER: Leonard Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Daisy Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: David Easton (Address): 916 Dawson ave

15 Filed OCT 7 - 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 4. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24. 1921. to October 4. 1921. that I last saw him alive on October 4. 1921. and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Cerebral compression.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Prolonged labor.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) L. J. Cleary. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem

DATE OF BURIAL: Oct 7 19

20 UNDERTAKER: David Easton

ADDRESS 916 Penna ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57493

D 57493

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Powell

(a) RESIDENCE. No. 1304 Wilmer ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~the WIFE of~~ Charlotte Powell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Evelina Delaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret E. Lead (Address) 1213 Etting St.

15 Filed OCT 7 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1921, to October 3, 1921, that I last saw him alive on October 3, 1921, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Hydronephrosis. Chronic Nephritis

Retention urin due to urethral Stricture

urethral calculus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis? Autopsy findings

(Signed) Cyrus J. Harris, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Oct 7 1921
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Penna ave

Burial Permit Filed

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57494

CERTIFICATE OF DEATH.

79 D 57494

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 530 Bore Alley ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Myers

(a) RESIDENCE: NO. 530 Bore Alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): OH!

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll County Maryland

PARENTS

10 NAME OF FATHER: Frank Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll County Maryland

12 MAIDEN NAME OF MOTHER: Betsy Boyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howdy Butt Maryland

14 Informant: James A Myers nephew
(Address) 1002 Fairmount Ave

15 Filed OCT 7 - 1921 19 ROBERT J. BRUTON Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6/1921

17 I HEREBY CERTIFY, That I attended deceased from Septr 11, 1921, to October 6, 1921, that I last saw her alive on October 5, 1921, and that death occurred, on the date stated above, at 9:30A m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis

(duration) Indefs. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What (test confirmed diagnosis)

(Signed) W. H. Howells, M. D.

, 19 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 8 1921
20 UNDERTAKER	ADDRESS
David Fowler	916 Pennsylvania

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57495 — 41 — D 57495

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Howard A Kelly Hospital Inc

CITY OF BALTIMORE: NO. 1418 Eutaw Place ST.: 14 WARD)

2-FULL NAME Caroline Butts Stoddard

(a) RESIDENCE. NO. 1063 East Ave. ST., Rochester N.Y. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Enoch V. Stoddard

6 DATE OF BIRTH (month, day, and year) Sept 18 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester N Y

PARENTS

10 NAME OF FATHER Isaac Butts

11 BIRTHPLACE OF FATHER (city or town) Irondequoit (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Edinborough (State or country) Scotland

14 Informant Enoch Home Stoddard (Address) Vine

15 Filed OCT 7 1921 ROBERT J. CRATTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1921, to Oct 6, 1921, that I last saw h[illegible] alive on Oct. 6, 1921, and that death occurred, on the date stated above, at 7:25 P.m.

The CAUSE OF DEATH* was as ~~follows~~:

Retroperitoneal tumor - malignant
Probably sarcomatous

CONTRIBUTORY (Secondary) Partial Intestinal obstruction (duration) yrs. 9 mos. ? ~~ds~~

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur C Primrose M. D.

10/6. 1921 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rochester N. Y.	Oct 7 1921
20 UNDERTAKER	ADDRESS
Chas. S. Black	742 W. North Ave

TION is very important. See instructions on back of certificates. ...it may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57496

CERTIFICATE OF DEATH.

15 V D 57496

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital St.: 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Lipson

(Residence in Baltimore: No. 2009 Linden Ave St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	

6-DATE OF BIRTH, October 1, 1921 (Month) (Day) 1 (Year)

7-AGE, ... yrs. ..... mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer) DOD

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Lipson

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jennie Weber

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Lipson

(Address) 2009 Linden Ave

15-

Filed OCT 7-1921, 191. ROBERT J. BRAUER Registrar.

Burial ... Death

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1, 1921, to October 6 1921, that I saw him alive on ..... 191 , and that death occurred, on the date stated above, at 10 29 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prolonged Labor

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Julius Holzsammer M. D.

Oct. 6, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale. DATE OF BURIAL, Oct. 7, 1921

20-UNDERTAKER May Levinson ADDRESS 1127 E. Balto St

Important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57497

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1537 N Strieker ST., 15 WARD)

REGISTERED No. D 57497

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Chambers

(a) RESIDENCE NO. 1537 N Strieker ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sallie Chambers

6 DATE OF BIRTH (month, day, and year): Aug 27-1864

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md Virginia

PARENTS

10 NAME OF FATHER: James B. Hualm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sallie Hualm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sallie Chambers

(Address): 837 N. Luzerne

15 Filed OCT 7-1921 ROBERT F. KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1921, to Oct 6, 1921, that I last saw h[illegible]live on Oct 4, 1921, and that death occurred, on the date stated above, at 7.20a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) ✓ yrs. 6 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) Geo E Shannon, M. D.

10/6, 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenhill

DATE OF BURIAL: Oct 8 1921

20 UNDERTAKER: W F Tuckner & Son

ADDRESS: Walbrook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 57498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

-170 D 57498

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1640 N. Carey ST. 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Zachariah Shenell

(a) RESIDENCE. No. 1640 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Shenell

6 DATE OF BIRTH (month, day, and year) Aug-30-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): City Stud Clerk D/K

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER Zachariah Shenell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City Md

12 MAIDEN NAME OF MOTHER Sophia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City Md

14 Informant (Address): Mary A. Shenell 1640 N. Carey St

15 Filed OCT 7 - 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from January 1st 1921, to October 6th 1921, that I last saw h[e] alive on Oct 6th 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death? Place of Abode

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Final

(Signed) Wm J Sullivan M. D.

(Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Oct 8 1921

20 UNDERTAKER: W. J. Tuckner & Sons

ADDRESS: Pa & North Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57499

64 D 57499

CERTIFICATE OF DEATH.

REGISTERED NO. 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 E Madison St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Magdalene Post

(a) RESIDENCE. No. 12 E Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	82	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None NOD

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Eugene Post

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Margaret Elizabeth Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Walter P Rowe

(Address) Sudbrook Park, Md.

15 Filed Feb. 6th, 1921

Registrar

OCT 7 - 1921

ROBERT [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5 1921

17

I HEREBY CERTIFY, That I attended deceased from August 10, 1921, to October 5, 1921,

that I last saw h[illegible] alive on Oct. 4, 1921,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency — Arterio Sclerosis

(duration) Almost yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Ludgrove Park Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. A. Naylor, M. D.

Oct 6, 1921 (Address) Pikesville, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Thomas, Garrison	Oct. 7th 1921
20 UNDERTAKER	ADDRESS
Henry W. Justice Sons Co.	Westwood

McCulloh

TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Vaquer

15055 — D 57500

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

X 150 D 57500

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.) WARD)

2-FULL NAME Olga Vaquer

(a) RESIDENCE NO. Havana Cuba ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced ~~Husband of~~ Mr. Ralph Vaquer (Father)
Room 86. Rennert Hotel Baltimore

6 DATE OF BIRTH (month, day, and year) May 4th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
		5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Havana
(State or country)

PARENTS

10 NAME OF FATHER Ralph Vaquer

11 BIRTHPLACE OF FATHER (city or town) Cuba
(State or country)

12 MAIDEN NAME OF MOTHER Mary Posada

13 BIRTHPLACE OF MOTHER (city or town) Cuba
(State or country)

14 Informant ..... C. H. H. Records
(Address)

15 Filed OCT 7 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1921, to Oct 6, 1921, that I last saw her alive on Oct 6, 1921, and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of Oct 6 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil Holman M. D.

10-6-21, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 7 1921
20 UNDERTAKER Emerich Eichlin & Sons Co	ADDRESS 1421 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57501

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 57501

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Rider

POLK

(a) RESIDENCE. No. None (Bay View) (23 yrs) ST., WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 77 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 77 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) ~~1844~~ about 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 77	yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER ~~Unknown~~ Washington Rider

11 BIRTHPLACE OF FATHER (city or town) ~~Unknown~~ (State or country) A.A.Co. Md

12 MAIDEN NAME OF MOTHER ~~Unknown~~ Mary Hodges

13 BIRTHPLACE OF MOTHER (city or town) ~~Unknown~~ (State or country) A.A.Co. Md

14 Informant Hospital Records, S.E. Linton

(Address) New City Hospital. 3513 Liberty Hgts.

15 Filed OCT 7 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from October 3, 1921, to October 5, 1921, that I last saw him alive on October 5, 1921, and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Face

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. E. Broadus. M. D.

10/6/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Oct 7 1921.

20 UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, [illegible])

ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

57502

CERTIFICATE OF DEATH.

79 D 57502

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 931 S. Ellwood Ave. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Braunschweiger

(a) RESIDENCE. No. 931 S. Ellwood ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 16-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Brick factory

(c) Name of employer Can-Br. Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry B. Braunschweiger

11 BIRTHPLACE OF FATHER (city or town) Not known
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Schoepflin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Rose Braunschweiger
(Address) 931 S. Ellwood Ave

15 Filed . 19 Registrar

OCT 7-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1921

I HEREBY CERTIFY, That I attended deceased from June 3 (1?), 1921, to Oct 5, 1921,

that I last saw h[illegible] alive on Oct 5, 1921,

and that death occurred, on the date stated above, at 5.55 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation following
Hypertrophy - ending in
Syncope

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute gastro enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Wright, M. D.

OCT 7 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Oct 8 1921
20 UNDERTAKER Zickler + Zickler	ADDRESS 1739 E Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baltimore, Md., Oct. 19, 1921.

I do hereby make oath that the statement given on Baltimore City Certificate of Death No. D-57502, that I attended the deceased, Frederick W. Braunschweiger, from Jan. (1 ?) to October 5, 1921, is not correct; same should read from June (1?) to October 5, 1921.

F. W. Braunschweiger
Physician

Subscribed and sworn to before me this 19th day of October, 1921.

Reed Smith
Notary Public.

---

ough; Chronic valvular heart disease; rstitial nephritis, etc. The contributory or intercurrent) affection need not be s important. Example: *Measles* (disease th), *29 ds.; Bronchopneumonia* (second- Never report mere symptoms or terminal such as "Asthenia," "Anemia" (merely e). "Atrophy," "Collapse," "Coma," "Con- Debility" ("Congenital," "Senile," etc.). Exhaustion," "Heart failure," "Hemor- rition," "Marasmus," "Old age," "Shock," Weakness," etc., when a definite disease tained as the cause. Always qualify all alting from childbirth or miscarriage, as *septicemia*," "PUERPERAL *peritonitis*," cause for which surgical operation was

For VIOLENT DEATHS state MEANS OF qualify as ACCIDENTAL, SUICIDAL, or or as *probably* such, if impossible to efinitely. Examples: *Accidental drown- by railway train—accident; Revolver ad—homicide; Poisoned by carbolic acid suicide.* The nature of the injury, as skull, and consequences (e. g., *sepsis*, y be stated under the head of "contribu- ommendations on statement of cause of ved by Committee on Nomenclature of n Medical Association.)

AL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 57503 — PLACE OF DEATH

CERTIFICATE OF DEATH (Womack)

6 AD 57503 — REGISTERED No. C

CITY OF BALTIMORE (No. Bateman ave Ext. ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Allen Womack

(Residence in Baltimore: No. Bateman ave Ext St. 40 yrs. — mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Oct (Month) 2 (Day), 1840 (Year)

7-AGE: 81 yrs. mos. 4 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: William Allen

11-BIRTHPLACE OF FATHER (State or country): Va.

12-MAIDEN NAME OF MOTHER: Sarah Trammell

13-BIRTHPLACE OF MOTHER (State or country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Harry L Heatwole

(Address) Bateman Ext

15

Filed OCT 7 1921, 191 — ROBERT J. [illegible] REGISTRAR

OCT 7 - 1921 — Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. (Month) 5 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to Oct 5, 1921, that I saw h[illegible] alive on Oct 5, 1921, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 7 yrs. mos. ds.

(Signed) J. M. Carstens M. D.

Oct 6, 1921 (Address) 1603 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death: yrs. mos. ds. | In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 7 1921

20-UNDERTAKER: W M Routson — ADDRESS: 2238 N Howard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57504

D 57504

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1903 N Franklyn ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Neubauer

(a) RESIDENCE NO. 1903 N Franklyn. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John. T Neubauer

6 DATE OF BIRTH (month, day, and year): July 24 1859 ~~Oct 5-1921~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Gollrid Schulze

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Lazetta Pfeneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John T Neubauer 1903 N Franklyn.

15 Filed OCT 7-1921 19 ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1921

17 I HEREBY CERTIFY, That I attended deceased from February, 1913, to Oct 5th, 1921, that I last saw her alive on Oct 5th, 1921, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (3rd attack)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis.

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Ephraim M. D.

Oct 5, 1921 (Address) 1 Dr Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: 10-8 1921

20 UNDERTAKER: Mrs Chas A J Robide ADDRESS: 1 Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57505
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

64 D 57505
REGISTERED NO.

CITY OF BALTIMORE: (No.) 4th Ave. & 4½ St. (Fairfield) ST.: 25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Miller

(a) RESIDENCE: (Usual place of abode) No. 4th Ave. & 4½ St. (Fairfield) ST., WARD.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriet Elizabeth Miller

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	×	×	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Has not worked
(c) Name of employer: for 3 or 4 years.

9 BIRTHPLACE (city or town) (State or country): (?) Virginia

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Mollie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Lucy Wright - (daughter)
(Address): White Hall, Md.

15 Filed OCT 7 1921 J E Watson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3rd, 1921, to Oct. 5th, 1921, that I last saw him alive on Oct 4th, 1921, and that death occurred, on the date stated above, at 12:20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis only

(Signed) Geo. B. Davis, M. D.

5/5, 1922 (Address) 211 Church St., Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Milford Co Va	Oct. 8 – 1921
20 UNDERTAKER	ADDRESS
S. H. Brown & Son	108 N. Monta

P. RR via Washington, N. & W. RR to Va.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57506

CERTIFICATE OF DEATH.

19

D 57506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2768 W. North ave (ST.) (WARD)

2-FULL NAME Charles Herbold.

(a) RESIDENCE. NO. 2768 W. North ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of / WIFE of Mary Herbold.

6 DATE OF BIRTH (month, day, and year) March 7 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79 yr.	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fredrick Herbold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Roth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Herbold

(Address) 2768 W. North ave.

15 Filed OCT 7 1921 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1921, to Oct. 5 1921, that I last saw him alive on Oct 5 1921, and that death occurred, on the date stated above, at 5.55 p.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) E. F. Radcliffe, M. D.

10/5/21 (Address) 2736 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 8 1921
21 UNDERTAKER	ADDRESS, 089
E. Schlosman & Son	Baltimore

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Bks.

Crane

D 57507 HEALTH DEPARTMENT—CITY OF BALTIMORE

91 ✓ D 57507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5th Floor Clinic (Ent'n WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Crane

(a) RESIDENCE NO. 237 W. Lanvale St ST., Balt md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70	70	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer) Teaching

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER William B. Crane

11 BIRTHPLACE OF FATHER (city or town) Kent Co (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah H. Ormes

13 BIRTHPLACE OF MOTHER (city or town) Kent Co. Md (State or country)

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed OCT 7-1921 ROBERT B. KRAUTER Registrar

Postal Permit Office

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 23 1921 to Oct 6 1921.

that I last saw h[illegible] alive on Oct 5 1921,

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Dorothy B. Hoffman, M. D.

Oct 6. 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edmondson Ridge — DATE OF BURIAL Oct. 10" 1921

20 UNDERTAKER Joseph P. Cook — ADDRESS 1003 N Gay St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57508

CERTIFICATE OF DEATH.

137

D 57508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST.: VI WARD)

2-FULL NAME Mrs. Minnie Brown

(a) RESIDENCE. No. 421 South Poppleton ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry M. Brown

6 DATE OF BIRTH (month, day, and year): Jan 18. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George Brawley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Harry M Brown

(Address) 421 S Poppleton St

15 Filed OCT 7-1921 ROBERT A. LEAUTER Registrar

Burial Permit Oct 8

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1921 to Oct. 6 1921, that I last saw h[illegible] alive on Oct. 6, 1921, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Child birth

(duration) yrs. mos. 45 ds.

CONTRIBUTORY, (Secondary) Puerperal Septicemia (General)

(duration) yrs. mos. 40 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Sept. 14, 1921

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) John A. Erwin M. D.

10/6, 1921 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct. 10 1921
20 UNDERTAKER	ADDRESS
J. R. Cook	1003 N. Gay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1 PLACE OF DEATH D-57509 REGISTERED NO. D-57509

CITY OF BALTIMORE: (No. 1458. Reynold. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. J Ozewicz.

(a) RESIDENCE. No. 1458. Reynold ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July. 10-20

7 AGE: Years 1 Months 2 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER St. Ozewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Sparzak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant St Ozewicz. (Address) 1458 Reynolds

15 OCT 7-1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1921, to Oct 6, 1921, that I last saw him alive on Oct 5, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (acute)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonic & cardiac failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) T. V. O'Leggard, M. D.

10/6, 1921 (Address) 423 L. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Oct 7 1921

20 UNDERTAKER: Wm Kaufmann — ADDRESS: 168 E

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 57510

CERTIFICATE OF DEATH.

D 57510

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 622 S. Bethel St ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Tomaszewski

(a) RESIDENCE. NO. 622 S. Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yo yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 9-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) " "
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Anthony Tomaszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bunal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anthony Tomaszewski
(Address) 622 S. Bethel

15 FILED OCT 7-1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5 19 21

17 I HEREBY CERTIFY, That I attended deceased from October 5, 1921, to October 5, 1921, that I last saw him alive on October 5, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

October 6, 1921 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Oct 7 1921

20 UNDERTAKER William Fiackowski ADDRESS 1618 Caster

TION is very important. See instruc

D 57511

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 ✓ Registered No. C D 57511

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2010 Fountain St ST.: 2 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Boleslaw Gmuske

(Residence in Baltimore: No. 211 Fountain St.: yrs. 2 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH July 17 (Month) (Day), 1920 (Year)

7 AGE yrs. 2 mos. 19 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 0 0 0

9 BIRTHPLACE (State or country) City

PARENTS

10 NAME OF FATHER Boleslaw Gmuske

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Josepha Praszesna

13 BIRTHPLACE OF MOTHER (State or country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Berger

(Address) 715 S Wolfe St

OCT 7 - 1921 Filed ..... 191 ROBERT J KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 6 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 ,1921, to Oct 6 1921, that I saw him alive on Oct 6 ,1921, and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Primary)

(Duration) — yrs. — mos. 4 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Alfred A Brudick M. D.

Oct 7 ,1921 (Address) 88 Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct 5 ,1921
20 UNDERTAKER	ADDRESS
Jacob Fiasconaro	428 S Exeter St

State CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should

Spec.–1-10-21–M&T–1500 Bks.

D 57512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Levick

(a) RESIDENCE NO. Union Post Dr ST., WARD Elma W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-4-870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	50	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. Va

PARENTS

10 NAME OF FATHER Otiver Levick

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. Va

12 MAIDEN NAME OF MOTHER Agnes Cardwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U Va

14 Informant H. H. Reeves (Address)

15 Filed OCT 7-1921 ROBERT J. KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5 1921

17

I HEREBY CERTIFY, That I attended deceased from 9-23, 1921, to 10-5, 1921, that I last saw him alive on 10-5, 1921, and that death occurred, on the date stated above, at 8.0 p. m.

The CAUSE OF DEATH* was as follows:

Myeloid Leukemia

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Sherman M. D.

10-6. 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview W. Va	Oct 8 1921
20 UNDERTAKER	ADDRESS
Chas G Bailey	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gilchrist

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

104

D 57513

CERTIFICATE OF DEATH.

D 57513

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 740 Ryan St. 21 Ward)

2-FULL NAME Paul Gilchrist

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 740 Ryan St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, ~~Married, Widowed,~~ or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Apr. 1920

7 AGE: 1 Years 6 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wallace Gilchrist

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Beatrice Tuttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis Md

14 Informant: Wallace Gilchrist

(Address): 740 Ryan st

15 Filed OCT 7 - 1921 19.. ROBERT I. KRAUTER Registrar

Deputy Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1921, to Oct 6, 1921, that I last saw h[illegible] alive on Oct 5 1921, and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 7 1921 (Address) 729 Orleans Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 7 19..
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57514 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57514

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1907 Eleven St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and the ward. Without No. 18.)

2-FULL NAME Sarah Mc Williams

(Residence in Baltimore: No. 1907 Eleven St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH Oct. (Month) 18 (Day), 1852 (Year)

7-AGE 68 yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) none 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Adam J. A. Heidner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Eichloe

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Mc Williams

(Address) 1907 E. Eleven St

15- Filed OCT 7-1921, 191.. H. Wehn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) [signature] M. D. (Coroner)

Oct 7, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Oct. 7, 1921

20-UNDERTAKER Josiah Syfer

ADDRESS 1600 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57515
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1911 D 57515
REGISTERED NO. C

CITY OF BALTIMORE: (No. 403 E. Fort Ave. ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary S. Eckhardt

(Residence in Baltimore: No. 403 E. Fort Ave. St.; 60 yrs., mos. ds.)

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. Any other information that may be desired may be given in addition.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 2nd, 1847
(Month) (Day) (Year)

7-AGE, 74 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Gill

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Betty York

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. C. Eberman

(Address) 1460 Battery Ave.

15- OCT 7-1911 ROBERT I. KRAUTER BOARD OF H'LTH

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5th, 1911.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 1911, to Oct 5 1911, that I saw her alive on Oct. 5 1911, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Interstit. Nephritis

(Duration) att 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) 3 yrs. mos. ds.

(Signed) Robt. L. C. Schmidt M. D.

Oct. 6, 1911. (Address) 1318 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cemetery

DATE OF BURIAL, Oct. 8, 1911

20-UNDERTAKER C. D. Hemming & Son

ADDRESS 1460 Battery Ave

Spec.—1-10-21—M&T—1500 Bks.

Wietrzykowski

D 57516 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 57516

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 S Bethel ST., 2 WARD)

2-FULL NAME John Wietrzykowski

(a) RESIDENCE NO. 915 S. Bethel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tabor

(b) General nature of industry, business, or establishment in which employed (or employer) — 040

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph wietrzykowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ewa Wietrzykowska
(Address) 915 S Bethel

15 Filed ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5th 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 2nd, 1921, to Oct 5th, 1921,

that I last saw h[illegible] alive on Oct 2nd, 1921,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary T B

(duration) yrs. 12 mos ... ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. F. Reis, M. D.

Oct 6, 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Jewish Hill — DATE OF BURIAL Oct 8 1921

20 UNDERTAKER John A Weber — ADDRESS 843 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 7-1921

Spec.—1-10-21—M&T—1500 Blks.

D 57517 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57517

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home

CITY OF BALTIMORE: (No. 114 Callander ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Emma Feuster

(a) RESIDENCE NO. 114 Callander ST., 16 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months 7 Days 14 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md.

PARENTS

10 NAME OF FATHER Frank M. Feuster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anna M. Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frank M Feuster

(Address) 114 Callander St

15 Filed ....., 19.... Registrar

Robert T. Harrison,

[Was 1927 Burial Permit Given?]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1921, to Oct 5, 1921, that I last saw her alive on Oct 5, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio-Pneumonia.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no. Physical Sign.

What test confirmed diagnosis?

(Signed) J. Thaxton Fox, M. D.

10/7, 1921 (Address) 888 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Oct 8 1921
20 UNDERTAKER	ADDRESS
Wm J. Tucker & Sons	847 N Carey

D 57518 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57518

CERTIFICATE OF DEATH.

79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1731 St. Paul ST. 17 WARD) Registered No. C

2 FULL NAME about Smith—

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1731 St Paul St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, June (Month) 18 (Day), 1844 (Year)

7-AGE, 77 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shawl
(b) General nature of industry, business, or establishment in which employed (or employer): manufacturer

9-BIRTHPLACE, (State or Country), Mass.

PARENTS.

10-NAME OF FATHER, A. Smith

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Myra Gilbert

13-BIRTHPLACE OF MOTHER (State or Country), Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr Royce Smith

(Address) 1731 Paul

15- Filed Oct 8, 1921, 191.... Robert P. Harrison, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Sclerosis
Fatty heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Prob) Pulmonary Embolism

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. T. Riley M. D.
(Coroner.)

Oct 5, 1921 (Address) 1639 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Prospect Hill Cemetery	Oct. 8, 1921
20-UNDERTAKER	**ADDRESS**
H Sander & Sons	1710 Fleet St.

PHYSICIANS should state plainly in ink in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH

17 1921

Spec.—8-24-14—M. & T.—2000 Blks.

D 57519 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57519

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 12 E. Centre St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W. Hughes

(Residence in Baltimore: No. 12 E. Centre St. 33 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October 1, 1838. (Month) (Day) (Year)

7-AGE, 73 yrs. 4 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Caterer Caterer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, James W. Hughes

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Ruffin

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary R. Hughes

(Address) 12 E. Centre St.

15- Robert P. Harrison,

Filed 7-1921, 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10 1921, to Oct. 5 1921, that I saw h[illegible] alive on Oct 5 191..., and that death occurred, on the date stated above, at 5.50 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis + Cardiac Dilatation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) 7 yrs. mos. ds.

(Signed) W. J. Carr M. D.

Oct. 6..., 191... (Address) 5 S. Mazella St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...moc. ...ds. In the State ...yrs. ...moc. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem't. DATE OF BURIAL, Oct. 8.., 1921

20-UNDERTAKER Geo. H. Holland ADDRESS 1631 Druid

Spec.—1-10-21—M&T—1500 Bks.

D 57520 150896

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57520

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Robinson

(a) RESIDENCE NO. 1235 Louis St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown 12 mos. years ds. How long in U. S., if of foreign birth? Unknown mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Johns Hopkins Hospital (Address) Baltimore

15 7-1921 ....., 19 ..... Registrar

Burial Permit Clerk.

Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-14 ....., 1921 ....., to 10-5 ....., 1921 .....,

that I last saw him alive on Oct 5, ..., 1921 .....,

and that death occurred, on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Dissecting Aortitis

Aortic Insufficiency

Myocardial Insuff.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Bateman M. D.

10-6, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL Oct. 8 1921

20 UNDERTAKER Chris. H. Johnson

ADDRESS 416 N. Pa.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57521 HEALTH DEPARTMENT—CITY OF BALTIMORE 78 D 57521

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Leslie ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milford H. Banks

(a) RESIDENCE (Usual place of abode) No. 1533 Leslie ST., WARD.

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Viola Banks

6 DATE OF BIRTH (month, day, and year) Oct. 19-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	31	11 mos.	17 das	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Viola Banks (Address) 1533 Leslie St

15 Filed Oct 7-1921 Robert F. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/2, 1921, to 10/6, 1921, that I last saw h[er] alive on 10/6, 1921, and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

and

Phthisis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bart Cutler, M. D.

, 19 (Address) 1134 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemt	Oct 10 1921
20 UNDERTAKER	ADDRESS
Geo. H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57522

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No..... ST. 5 WARD)

Municipal Tuberculosis Hospital

2-FULL NAME Frank Murphy

(a) RESIDENCE. No. 100 N. Front st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address) M.T.H.

Filed ..... 19 Registrar

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to Oct. 6, 1921, that I last saw him alive on Oct. 6, 1921, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and enteritis (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglacca, M. D.

10-6-21 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 7 1921

8570

Commissioner Health

OCT 7 1921

UNIVERSITY OF MARYLAND

CAUSE OF DEATH must be plainly written. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57523

D 57523

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Robinson

(a) RESIDENCE. NO. 1009 McCullough St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte, ~~South~~ North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) New City Hospital Records, ~~New City Hospital.~~

15 10-7-1921 Robert T. Hartnett, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4 1921

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1921, to October 4, 1921, that I last saw him alive on October 4, 1921, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis; lobar pneumonia; tuberculous meningitis; Pneumococcus Septicemia (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Clyde M. Reed, M. D.

10/4/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND

OCT 7 1921

Commissioner of Health,

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 57524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57524

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 122 East St., Baltimore, Md
CITY OF BALTIMORE: (NO. ..... ST., 5 WARD)

2-FULL NAME Edith Daisy Wilson

(a) RESIDENCE NO. 122 East ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work infant 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Wilson

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Cassel

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland.

14 Informant Horace G. Stewart M. D.
(Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,
Burial Permit 18563

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1921. to Oct. 5, 1921.
that I last saw her alive on Oct. 5, 1921.
and that death occurred, on the date stated above, at 9:10 a. m.
The CAUSE OF DEATH* was as follows:
Prematurity

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) None.
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Born Johns Hopkins Hosp.
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? 3½ lbs at birth.
(Signed) Horace G. Stewart M. D.
10/6, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JOHNS HOPKINS HOSPITAL

DATE OF BURIAL
OCT 7 1921

20 UNDERTAKER
Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57525

CERTIFICATE OF DEATH.

104

D 57525

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2123 Vine ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Unknown

(a) RESIDENCE. No. ..... ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7 1924

7 AGE — Years: — Months: 6 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant .....
(Address)

15 Filed Sept 8 1921 Albert E. Harrison, Registrar

1921 Mar 18663

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1921, to Sept 7, 1921, that I last saw h.. alive on Sept 7, 1921, and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis
Emesis
6 hours.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robt. J. Murray, M. D.

9-8, 1921 (Address) 510 N. Fremont ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health — ADDRESS

Per. Wm. H. Woodall

TION is very important. See instructions on back of certificates.

D 57526 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57526

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 184

CITY OF BALTIMORE (No. Dental Practice ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ooo
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelyn Viola Fake

(Address) Bank St

15- Robert P. Harrison,

Filed....., 191.....

7-1921 Burial Permit Clerk Registrar.

18564

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Pulmonary

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Calvin Van Poole M. D.
(Coroner)

Oct 6 '21, 191.. (Address) 98 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health. OCT 7 1921

Dr. Wm. R. WOODALL

CAUSE OF DEATH must be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57527.

CERTIFICATE OF DEATH.

28 D 57527

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Latonia ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine McGrain

(a) RESIDENCE. NO. 7 Latonia ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph McGrain

6 DATE OF BIRTH (month, day, and year) March 19 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework Home

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Mathew Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Joseph McGrain
(Address) 7 Latonia ave

15 Filed Robert P. Harrison, Registrar

7 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1921, to Oct 5, 1921, that I last saw h.. alive on Oct 4, 1921, and that death occurred, on the date stated above, at 8.05 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs
a Months, Glands

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Test

(Signed) W. C. Burns M. D.

Oct 7, 19 (Address) 2218 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemy	Oct 8 1921
20 UNDERTAKER	ADDRESS
Elmer W Conklin	324 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57528

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH CITY OF BALTIMORE (No. Rail Road Ave Washington St.; [illegible] WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F Henderickson

(Residence in Baltimore: No. Rail Road Ave Washington St.; 2 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Aug. 8, 1846. (Month) (Day) (Year)

7-AGE. 75 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) B&O

9-BIRTHPLACE, (State or Country). New Jersey

PARENTS.

10-NAME OF FATHER. Asked. Not Known

11-BIRTHPLACE OF FATHER (State or Country) Asked. Not Known

12-MAIDEN NAME OF MOTHER Asked. Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Asked. Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Alice V Henderickson

(Address) Rail Road Ave Washington St

15-

Filed OCT 7-1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920, to Oct. 6 1921, that I saw h-- alive on Oct 6 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

~~Senile Degeneration~~ - Arteriosclerosis Chron Bright

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. 1 ds.

(Signed) C. H. Beeler M. D.

Oct. 7, 1921 (Address) Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Oct 8, 191..

20-UNDERTAKER R S Marshall ADDRESS 3[illegible]

Important. See instructions on Back of Certificate.

Spec. 1-10-21 M&T 1500 Bks.

151 D 57529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 39-091 D 57529

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Johns Hopkins Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Hogan

(a) RESIDENCE NO. Mountville, W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced (or) WIFE of Sabetha Hogan

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed 10-8 1921 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-2 1921, to 10-7 1921,

that I last saw him alive on Oct. 7 1921,

and that death occurred, on the date stated above, at 7.20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of jaw

(duration) yrs. 3 mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia (broncho)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Oct 5, 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinic

(Signed) Louis Hellman M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mountville W. Va Woodlawn Cemetery

DATE OF BURIAL Oct 8 1921

20 UNDERTAKER John Herwig & Co

ADDRESS 2008 Orleans

CAUSE OF DEATH to be filled in by physician. Information on back of certificates. ATION is very important. See instructions on back of certificates.

7-1921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57530

CERTIFICATE OF DEATH.

D 57530

1-PLACE OF DEATH — CITY OF BALTIMORE (No. 3035 ~~Hola~~ Westwood Way St.; 15 Ward) — REGISTERED No. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Valentine Jechaline

(Residence in Baltimore: No. 3035 Westwood Way St.; 34 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, June (Month) 9 (Day), 1870 (Year)

7-AGE, 51 yrs. 3 mos. 26 ds. — If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ludwig Jechaline

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Gertrude Selig

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agatha Boerner

(Address) 3035 Westwood Way

15-

Filed OCT 7 1921, 191.... Registrar.

Robert P. Harrison,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of lungs

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Sclerochymatosis Hypertrophica

(Duration) ....yrs. 3 mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Oct. 7 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Oct. 8, 1921.
20-UNDERTAKER John Hennig & Co	ADDRESS 2008 Orleans

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57531

CERTIFICATE OF DEATH.

D 57531

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Franklin Square Hospital. ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Lambert.

(Residence in Baltimore: No. 212 N. Kenwood Ave. St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 11 (Day), 1852 (Year)

7-AGE, 69 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hat Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George Lambert

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Mary Burkhart

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L. C. Majors

(Address) 212 N Kenwood Ave

15- Filed ....., 191.....

Robert P. Harrison
Registrar.

Burial Permit Issued

OCT 7 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 6 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to October 6 1921, that I saw him alive on October 6 1921, and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows: Malignant Prostatic Hypertrophy.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism of Brain,

(Duration) yrs. mos. ds.

(Signed) Louis M. Tomko M. D.

Oct. 6, 1921. (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? At home.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Oct 10, 1921.

20-UNDERTAKER John Herwig & Co — ADDRESS 2005 Eutaw St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57532

CERTIFICATE OF DEATH.

91 D 57532

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Warner

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 0 15

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed 19 Registrar

7-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from December 20, 19 19, to October 6, 1921, that I last saw h. alive on October 6, 1921, and that death occurred, on the date stated above, at 10:25 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

10/7/21 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Oct 8 1921

20 UNDERTAKER John Herwig V C

ADDRESS 2008 Aliceanna

CAUSE OF DEATH to be plainly written. See instructions on back of certificates.
TION is very important.

Insc.—6-9-19—H. P. Co.—1000 Bks.

D 57533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57533

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Mt Hope Retreat St. 28th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Saylor

(a) RESIDENCE. No. Baltimore St. 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Dont Know yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Housework -

(c) Name of employer Dont Know

9 BIRTHPLACE (city or town) (State or country) Born Some where in S. America (?)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know (State or country) Dont Know -

14 Informant (Address) Was transferred from Bay View - No History.

15 Filed . 19 Registrar

1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 19 21

17

I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1920, to Oct 7, 1921, that I last saw h alive on Oct 7, 1921, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis (R. Hemi-) Post Cerebral Hemorrhage -

(duration) abt 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Dementia Senile -

abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Oct 8 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODES, [illegible]) — ADDRESS: 106 W. NORTH AV

CAUSE OF DEATH must be plainly stated, so that a physician may intelligently classify it. Neglect of this precaution may cause delay in burial permit. Carefully read rules and instructions printed on back of certificates. ATTENTION is very important. See instructions on back of certificate.

Robert P. Heffron, Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57534

CERTIFICATE OF DEATH.

79 D 57534

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 Spalding Av ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Tristram Martin

(a) RESIDENCE. NO. 322 Spalding Av ST., 27 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 84 yrs. 9 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ellen Martin

6 DATE OF BIRTH (month, day, and year) Dec-14-1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real-Estate Opr

(b) General nature of industry, business, or establishment in which employed (or employer) Real-Estate

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Trappe Talbot Co. Md

PARENTS

10 NAME OF FATHER John Stevens Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trappe Talbot Co. Md

12 MAIDEN NAME OF MOTHER Eliza Jane Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Trappe Talbot Co. Md.

14 Informant Mr. Robert Martin (son)

(Address) 322 Spalding ave.

15 Filed Oct 19 1921 Robert L. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7th 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10th, 1921, to Oct. 7th, 1921, that I last saw him alive on Oct. 6th, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endocarditis of about 2 months duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

10 or 12 years (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Johns Hopkins

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Urine & sputum exam.

(Signed) Edwin C. Dixe, M. D.

, 19 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL Oct 13 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Secretary)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate is void unless all items are properly answered. See instructions on back of certificates. TION is very important.

7-1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57535

CERTIFICATE OF DEATH.

40 D 57535

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3214 Westwood Avenue ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Parodi

(a) RESIDENCE. NO. 3214 Westwood Avenue ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 49 yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. G. Schiaffino

(Address) 417 E. Baltimore St.

15 Date 19 Registrar

T 7-1921
-2150

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1921, to Oct. 5, 1921, that I last saw her alive on Oct. 5, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall-Bladder.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Passano, M. D.

Oct. 7, 1921 (Address) 234 E Ball St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/8 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57536

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Plitt

(Residence in Baltimore: No. 19 N. Chester Street St.; 58 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) 25 (Day), 1863 (Year)

7-AGE, 58 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Plitt

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER ? Scherer

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. L. Plitt

(Address) 19 N. Chester

15- Filed 7-1921, 191.....

Robert P. Harrison,
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 4 1921, to October 7 1921, that I saw h[im] alive on October 7 1921, and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

5

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Louis M. Frank M. D.

Oct. 7, 1921. (Address) Grant & Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 19 North Chester

Former or usual residence 19 North Chester

19-PLACE OF BURIAL OR REMOVAL, Baltimore County — DATE OF BURIAL, Oct. 8, 1921

20-UNDERTAKER William Cook — ADDRESS 5028 North

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Angel)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57537

D 57537

CERTIFICATE OF DEATH.

REGISTERED NO. 108

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (NO. 176 N. Broadway ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret Angel

(a) RESIDENCE. NO. 518 E. 20th St. City ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John T Angel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary J Holbrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Miss Amanda E Angel 518 E 20th St

15 Filed Oct 7-1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5-1921, 1921, to Oct. 6 - 1921.

that I last saw h[illegible] alive on Oct 6 1921.

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis
Ruptured.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct. 5-1921

Was there an autopsy? No Operation

What test confirmed diagnosis? W. D. Noble M. D.

(Signed) (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem Co DATE OF BURIAL Oct 10 1921

20 UNDERTAKER Wm Lee ADDRESS 526 E Madison

CAUSE OF DEATH in plain terms, so that it may be understood by the public authorities. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks. (Alberta C. Hommerbocker)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57538 — 33 D 57538

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1244 Cleveland St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma C Hommerbocker

(a) RESIDENCE. No. 1244 Cleveland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Hommerbocker

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie C. Keytler.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Charles Hommerbocker.
(Address) 1244 Cleveland St.

15 Filed OCT 7 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 6, 19 21, to Oct 6, 19 21,
that I last saw h alive on Oct 6, 19 21,
and that death occurred, on the date stated above, at 1 11 m.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
(duration) yrs. 5 mos. ds.
CONTRIBUTORY Tuberculosis
(Secondary)
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Henry Boyle, M. D.
7-11, 19 21 (Address) 102 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	10-10 — 1921

20 UNDERTAKER Wm. Cook 502 E. North Ave. ADDRESS

TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 57539 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 57539

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Madison ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth McCullough

(a) RESIDENCE. No. 1420 Madison ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~WIFE~~ James H. McCullough

6 DATE OF BIRTH (month, day, and year) May 5 - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co. Penn

PARENTS

10 NAME OF FATHER —Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Co. Penn.

12 MAIDEN NAME OF MOTHER Elizabeth Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Co. Penn.

14 Informant James H. McCullough (Address) 1420 Madison ave.

15 Filed Oct 8 1921 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from October 1919 to Oct. 7th 1921

that I last saw her alive on Oct 7th 1921

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Arter Sclerosis
(Heart & Kidney Disease)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cornea

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis? Chronic Myocarditis

(Signed) Wilmer Brinton M. D.

19 (Address) 1 W. Cor. Calvert & Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Freedman York Penn.	Oct 10 1921
20 UNDERTAKER	ADDRESS
Wm. J. Loveman Son	1428 E. Monument

CAUSE OF DEATH in plain terms, so that it may be understood by the people. Read carefully the back of certificates. TION is very important. See instructions on back of certificates.

D 57540

D 57540
Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4604 York Rd ST.; 27 WARD)

2-FULL NAME Lorenzo B Hopkins

(a) RESIDENCE. NO. 4604 York Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1905-10-19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18 yrs	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto co Md

PARENTS

10 NAME OF FATHER L W Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Estell Basey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Estell Hopkins
(Address) 4644 Jackson Rd

15 Filed 8-1921 19 Robert F. Jackson Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 1921, to Octobr 7 1921, that I last saw him alive on Oct 7 1921, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Lehmn Myocarditis
Chronic Endocarditis

(duration) 12 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Long Green Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & albumin

(Signed) George W Bishop, M. D.

10/12, 1921 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Coan Virginia	9/10 1921
20 UNDERTAKER Edward Toulson	ADDRESS 12-14 N Green St

mation should be carefully answered, so that it may be properly classified. Use only accepted terms, so that it may be properly classified. Use only accepted terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57541

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57541

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward E Garrett

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., 34 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23 yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist's helper

(b) General nature of industry, business, or establishment in which employed (or employer) --- 031

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Baltimore Md.

15 Filed Oct 8-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. It is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1921 to Oct. 5, 1921.

that I last saw him alive on Oct. 5, 1921.

and that death occurred, on the date stated above, at 10'40 P.M.

The CAUSE OF DEATH* was as follows:

Myolitis transverse) Syphilitic)

Sept 9,/21 (duration) -- yrs. -- mos -- ds.

CONTRIBUTORY (Secondary) Cystitis acute

9/10/21 (duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R. Payne M. D.

Senior Surgeon (R)

10/6 1921 (Address) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL Oct 7, 21

20 UNDERTAKER Sol Guinsan

ADDRESS 1147 E. Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 57542

D 57542

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N Curley ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Antonio Grande

(a) RESIDENCE. NO. 21 N Curley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Michael Grande

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Delsordo

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Michael Grande
(Address) 21 N Curley

15 Filed Robert P. Harrison, Registrar
8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1921, to Oct 7, 1921, that I last saw her alive on Oct 7, 1921, and that death occurred, on the date stated above, at 3P0 p. m.

The CAUSE OF DEATH* was as follows:

Premature separation of Placenta

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Remagne M. D.

Oct 8, 1921 (Address) 2314 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cem. — DATE OF BURIAL: Oct 8 1921

20 UNDERTAKER: Wendell Ripple & Son — ADDRESS: 37 S Amm

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57543 ~~D 57543~~ 120

D 57543

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 W. Lombard ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella A. Sheppard

(a) RESIDENCE. NO. 2422 W. Lombard ST. 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	1	13	

8 OCCUPATION OF DECEASED 009

(a) Trade, profession or particular kind of work Statistician

(b) General nature of industry, business, or establishment in which employed (or employer) State Board of Health

(c) Name of employer Jersey City N.J.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Charles Sheppard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna B. Meister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charles Sheppard

(Address) 2422 W. Lombard St.

15 Filed Robert P. Harrison, Registrar

OCT 8 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 1921 to Oct 6 1921, that I last saw h[illegible] alive on Oct 5 1921, and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis (chronic)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Influenza -

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of -

Was there an autopsy? no -

What test confirmed diagnosis? clinical

(Signed) J. Wesley Hoag M. D.

Oct 7 1921 (Address) 724 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct. 8 1921
20 UNDERTAKER Geo. L. Schwab & Bro	ADDRESS 1101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57544 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57544

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 Raborg (St.:) 4 (Ward) 8

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas D. Hull

(a) RESIDENCE. No. 702 Raborg St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dallas Md.

PARENTS

10 NAME OF FATHER Lelar Hull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lincoln County N.C

12 MAIDEN NAME OF MOTHER Maggie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Churchtown Md

14 Informant Lelar Hull

(Address) 702 Raborg

15 Filed Robert P. Harrison, Registrar

OCT 8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Oct 8, 1924, that I last saw h alive on Oct 7, 1924, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Eclampsia

2 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) W Hooping Cough Laid to have (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

(Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 8 1924
20 UNDERTAKER	ADDRESS
Chas Scott Hooper	406 W Conway St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57545 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57545

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Pearl A ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Spratley

(a) RESIDENCE. NO. 502 Pearl ST.. WARD.
(Usual place of abode) (If nonresident give rity or town and State)

Length of residence in city or town where death occurred 0 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Spratley

6 DATE OF BIRTH (month, day, and year) ~~Jan~~ 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevador 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer STORR

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (rity or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (rity or town) " (State or country)

14 Informant Elmer Toplines (Address) 502 Pearl St

15 Filed 8-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1921, to Oct 16th, 1921, that I last saw h[illegible] alive on Oct 6, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 1 ds.

18 Where was disease contrarted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Goldman, M. D

, 19 (Address) 606 N Grant Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homiridal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Oct 9 21

20 UNDERTAKER Daniel Foster — ADDRESS 916 Penna Ave

CAUSE OF DEATH in plain terms. Omission of certificates. See instructions on back of certificate. TION is very important.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63-001 D 57546

D 57546

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 235 N. Fulton ST.: 19 WARD

2-FULL NAME Joseph Martin Shellisey Jr

(a) RESIDENCE. NO. 235 N. Fulton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9th 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5 -	5 -	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Martin Shellisey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Edith Eichman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Joseph Martin Shellisey 235 N. Fulton

15 Filed Robert P. Harrison Registrar

1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1921, to Oct. 7, 1921, that I last saw h in alive on Oct. 7, 1921, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Enteric. Poliomyelitis,
Complications, Uremia, & Coronary Thrombosis
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) [illegible] Dennison, M. D.

19 (Address) 23 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral	Oct 10 1921
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57547

CERTIFICATE OF DEATH.

104 D 57547

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 918 S. Curley St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sofia Rozek

(a) RESIDENCE. No. 918 S. Curley ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21-1921

7 AGE Years ... Months ... Days 15 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Philip Rozek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jozefa Wozniak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Philip Rozek
(Address) 918 S. Curley St.

15 Filed ..., 19 ... Registrar

OCT 8 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1921.

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1921, to October 7, 1921, that I last saw h.. alive on October 7, 1921, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Frank A. Jones M. D.

10/7. 1921 (Address) 2437 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Oct 8 1921

20 UNDERTAKER, Wm Falkowski — ADDRESS 168 E...

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 57548

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 157 Augusta Ave (St.) (20 Ward)

2-FULL NAME Sally M. Comegys.

(a) RESIDENCE. (No.) 157 Augusta Ave (St.)

(Usual place of abode) Ward.

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Bartus Comegys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore

12 MAIDEN NAME OF MOTHER Eveliana Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Miss Nellie Schuman

(Address) 157 Augusta Ave

15 Filed OCT 8 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to Oct 6, 1921, that I last saw her alive on Oct 6th, 1921, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) E. Krug, M. D.

, 19 (Address) 1733 Lindenau.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 10 1921
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Sons Co.	Orchard & Aisquith Sts

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57549 D 57549

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Moses

(a) RESIDENCE. No. Entaw Plaza (Brooks Lane) ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Moses Moses

6 DATE OF BIRTH (month, day, and year): April 5 1837

7 AGE: Years 84 Months 5 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 937

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Emanuel Levi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bessie Plant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: M Moses (Address): Esplanade Apts

15 Filed OCT 8-1921 F.H. Wehr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to Oct 6, 1921, that I last saw h.. alive on Oct 6, 1921, and that death occurred, on the date stated above, at 8½ a m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis - nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): acute dilatation of heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Lentz, M. D.

Oct 7. 1921 (Address) 2040 Entaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: Oct 9th 1921

20 UNDERTAKER: David Sondheim — ADDRESS: 1184 W. Baltimore

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57550 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57550

CERTIFICATE OF DEATH.

81

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Eutaw Place ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dina Lilles

(a) RESIDENCE. NO. 1813 Eutaw Place ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lilles

6 DATE OF BIRTH (month, day, and year) March 27/1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Solomon Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert Hyman (Address) 1813 Eutaw Pl

15 Filed OCT 8 - 1921 19 F. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1920, to Oct 7, 1921, that I last saw h.. alive on Oct 7, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gen. Arterio Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Simon Lilles, M. D.

, 19 (Address) 1134 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Sheldon	Oct 9 1921

20 UNDERTAKER Harry Goudelman ADDRESS 1808 Mt Royal Ave

TION is very important. See instructions on ba...

(Carpenter) ✓

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57551

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 2425 Oak St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Carpenter

(a) RESIDENCE. NO. 2425 Oak St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Anthony Carpenter

6 DATE OF BIRTH (month, day, and year): Feb 22. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Walter Gremand

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Julia Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Julia Gremand 2425 Oak St

15 Filed 8-1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18 1921, to Oct 6 1921.

that I last saw her alive on Oct 6 1921.

and that death occurred, on the date stated above, at 11½ m.

The CAUSE OF DEATH* was as follows:

Acute Phthisis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) R. Garland Churchill, M. D.

Oct. 1921 (Address) 1534 O St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Oct. 9 1921

20 UNDERTAKER: Felix B. Pyz — ADDRESS: 102 E Baltimore St

TION is very important. See instructions on back of certificates.

(Nowak)

D 57552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57552

CERTIFICATE OF DEATH.

151

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 717 S. Bond St. ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresa Nowak

(Residence in Baltimore: No. 717 S. Bond St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 6, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael Nowak

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Anna Zyzmuntz

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Nowak

(Address) 717 S. Bond St.

15-

Filed ..... Robert P. Harrison, ...
Registrar.

8-1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debilities

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Lynch Bailey M. D.
(Coroner.)

Oct 8, 1921, (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Oct 8, 1921

20-UNDERTAKER John M. Weber

ADDRESS 1803 Bank St

CAUSE OF DEATH to be filled in plainly and important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57553

CERTIFICATE OF DEATH.

79 D 57553

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Tyson St. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Fuller

(Residence in Baltimore: No. 413 Tyson St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May 1st, 1869
(Month) (Day) (Year)

7-AGE, 52 yrs. 5 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Adam Fuller

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Elizia Mathews

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie A. Bouza

(Address) 413 Tyson St.

15-

Filed Oct 8-1921 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16 1921, to Oct 6 1921, that I saw h[illegible] alive on Oct 6 1921, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. 2 mos. ds.

(Signed) J. B. Fulenbaugh M. D.

10/7, 1921. (Address) 1901 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Oct. 10., 1921

20-UNDERTAKER George A. Holland — ADDRESS 1631 Druid Hill Ave

important. See instructions on back of certificate.

State—6-0-19—H. P. Co.—1000 Blks.

D 57554 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57554

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE. NO. 608 N. Redwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Married

5a If married, widowed, or divorced HUSBAND of - (or) WIFE of Nellie Smith

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none -

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Isabella Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Nellie Smith (Address) 228 Church st

15 Filed 8-1921 19 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 23 1921, to Oct. 6 1921, that I last saw him alive on Oct. 6 1921, and that death occurred, on the date stated above, at 3:30a. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aneurism right carotid artery with rupture & hemorrhage

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes -

What test confirmed diagnosis? Findings Signs & Symptoms

(Signed) John J. Ewell M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ct	Oct 8 1921
20 UNDERTAKER	ADDRESS
J W & Broward Son	108 N Monty

TION is very important. See instructions on back of certificates.

Spec.- 1-10-21 - M&T - 1500 Bks.

D 57555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57555

CERTIFICATE OF DEATH.

X 74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Gold

(a) RESIDENCE NO. 445 S. Maine St. Providence R. I. WARD Providence R. I.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown Bor. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruben Gold

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Davis

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Hallis ?

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Johns Hopkins Hospital (Address)

15 Robert P. Harrison, ..., 19 Registrar

8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-29, 1921, to 10-5, 1921, that I last saw h alive on 10-5, 1921, and that death occurred, on the date stated above, at 10.24 a m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Gray, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Providence, R. I.	10-8- 1921
20 UNDERTAKER	ADDRESS
Jack n Louis	1411 E. Balto.

CAUSE OF DEATH must be filled in on back of certificates. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57556

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1918 Cecil Ave. Baltimore.

CITY OF BALTIMORE: No. 1918 Cecil Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Victoria Zimmerman

(a) RESIDENCE No. 1918 Cecil Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4 - 1899

7 AGE 22 Years 3 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Mfr

(c) Name of employer J. G. Mahlenbrock

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Victor A. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Spindler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katharine Zimmerman

(Address) 1918 Cecil Ave

15 Filed Oct 8-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8- 1921

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to October 8, 1921, that I last saw her alive on Oct. 7, 1921, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Tuberculous Laryngitis (duration) yrs. 3. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) W. R. Ingram M. D.

, 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL Oct. 11 1921

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificates.

Form 6-9-19—H. P. Co.—1000 Blks.

D 57557 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57557

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4 St.: Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Crist-

(a) RESIDENCE No. 222 St. paul St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. 5 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 990

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas Crist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Rose Griger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant St Vincent de Paul Records (Address) 222 St Paul

15 Filed 8-1921 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Oct 6, 1921, that I last saw him alive on Oct 6, 1921 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis Colitis

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt Sinai Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W B Jones, M. D.

Oct 7, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	10/8/21
20 UNDERTAKER Geo A Farley Fayette & Fulton	ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57558 D 57558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 57558

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1112 S Clinton ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Markiewicz

(a) RESIDENCE. No. 1112 S Clinton ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., If of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of School Child

6 DATE OF BIRTH (month, day, and year) 1907 - Dec 14

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md U S A

PARENTS

10 NAME OF FATHER John Markiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Posinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John Markiewicz 1112 S Clinton St

15 OCT 9-1921 [illegible] KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1921, to Oct 5, 1921, that I last saw h[illegible] alive on Oct 5, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J Davidson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 10 1921
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	[illegible]

CAUSE OF DEATH. Fill in all the blanks. Physician must sign and fill out Medical Certificate. Undertaker must fill out his part. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

57559 HEALTH DEPARTMENT—CITY OF BALTIMORE 57559

D 57559 CERTIFICATE OF DEATH. 151 D 57559

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Ashland Ave ST., 10 WARD)

2-FULL NAME George Doepfler

(a) RESIDENCE NO. 1409 Ashland Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 6th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.
(State or country) Md

PARENTS

10 NAME OF FATHER Peter J. Doepfler

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah J. Virkel

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.
(State or country) Md

14 Informant Peter Joseph Doepfler
(Address) 1409 Ashland Ave

15 OCT 9-1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th 1921, to Oct 8th 1921, that I last saw him alive on Oct 8th 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Thrush
Premature Birth
(duration) 2 yrs. mos. 2 ds.
Stomach
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (est. confirmed) diagnosis?

(Signed) J. W. Schnee M. D.

Oct 8th, 1921 (Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 8 1921
20 UNDERTAKER	ADDRESS
Feeney Hoeck & Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

57560 HEALTH DEPARTMENT—CITY OF BALTIMORE 57560

D 57560 CERTIFICATE OF DEATH. 151 D 57560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Ashland Ave 10 ST.. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Doerfler

(a) RESIDENCE NO. 1409 Ashland Ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city, Md

PARENTS

10 NAME OF FATHER: Peter J. Doerfler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City Md

12 MAIDEN NAME OF MOTHER: Mary J. Disbel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto city Md

14 Informant: Peter Joseph Doerfler
(Address): 1409 Ashland Ave

15 OCT 9-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1921, to Oct 8th, 1921, that I last saw him alive on Oct 8th, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Coma

Spontaneous Coagulation

(duration) 5 hrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H Geier, M. D.

, 19 (Address) 1301 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 8 1921
20 UNDERTAKER	ADDRESS
Henry Koeckes Son	1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

57561

HEALTH DEPARTMENT—CITY OF BALTIMORE

57561

D 57561

CERTIFICATE OF DEATH.

X 51

D 57561

1-PLACE OF DEATH Union Memorial Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. Wm (Mamie) Acree

(a) RESIDENCE. No. 403 E. Bolton St. Savannah ST., Ga WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White American	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Wm. Acree

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) In country Jefferson Co. Ga.

PARENTS

10 NAME OF FATHER Wm C. Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisville Ga.

12 MAIDEN NAME OF MOTHER Fanny Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville Ga.

14 Informant Mrs. C. A. Bell (Address) 2221 Eastern Place N.W. Washington

15 Filed OCT 9-1921 ROBERT A. KRAUTH Registrar Basis Parish Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1921, to Oct. 8, 1921, that I last saw her alive on Oct. 8, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Toxic Exophthalmic goitre

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Savannah, Ga.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. T. Kinney Jr. M. D.

Oct 8th. 1921 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camilla Ga	Oct 8 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Co	Camilla Ga

TION is very important. See instructions on back of certificates.

Clarice Everton ✓

57562 HEALTH DEPARTMENT—CITY OF BALTIMORE 175-005-7562

D 57562 CERTIFICATE OF DEATH. D 57562

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital ..... St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarice Everton

(Residence in Baltimore: No. 1024 E. Madison St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. February 11th, 1918 (Month) (Day) (Year)

7-AGE. 3 yrs. mos. ds. If LESS than 1 day, hrs. or mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Clarence Overton

11-BIRTHPLACE OF FATHER (State or Country). Elizabeth City N.C.

12-MAIDEN NAME OF MOTHER Clara Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Overton

(Address) 1624 E. Madison st.

15- OCT 9-1921 ROBERT J. KRAUTER Burial Permit Clerk

Filed.....

CAUSE OF DEATH. In the plain words of a layman. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatism Heart

Endo (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

10 S. Eutaw (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Oct 10th 1921

20-UNDERTAKER Jas. M. Skinner

ADDRESS 625 E. Mad. St

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 57563

CERTIFICATE OF DEATH

D 57563

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Pennsylvania ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Schmidt

(Residence in Baltimore: No. 1816 Pennsylvania ave St.; 2 yrs. mos. ds.)

in Balto Ay 19 Jan.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: April 24, 1859 (Month) (Day) (Year)

7-AGE: 62 yrs. 5 mos. 14 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE (State or country): Austria

PARENTS

10-NAME OF FATHER: Henry Schmidt

11-BIRTHPLACE OF FATHER (State or country): Austria

12-MAIDEN NAME OF MOTHER: Ida Menkes

13-BIRTHPLACE OF MOTHER (State or country): Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Schlan

(Address) 1816 Penn Ave.

OCT 9 - 1921 Filed 191

[illegible] & REGISTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October 8, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febn 20, 1921, to, Atoben 8 1921, that I saw h[illegible] alive on Atoben 8 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 0 yrs 6 mos. 18 ds.

Contributory (SECONDARY)

(Duration) yrs mos. ds.

(Signed) Samuel Silverstein M. D.

Octo 8, 1921 [Address] 22 S. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Mar Carmel

DATE OF BURIAL: Oct 9 1921

20-UNDERTAKER: Thos Kerrigan

ADDRESS: 117 E. Baltimore St

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D57564 D/57564

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bank Main, Lakeland ½ ST.; ... WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Copperthite,

(Residence in Baltimore: No. Bank Main St. Lakeland St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, October (Month) 8 (Day), 1921 (Year)

7-AGE, ... yrs. ... mos. ... ds. If LESS than 1 day, 1 hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... none
(b) General nature of industry, business, or establishment in which employed (or employer) ... none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter H. Copperthite,

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lydia S. Fouty,

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H Lawrence Kuhn MD

(Address) Lakeland, Ames

15-

Filed Oct 9/21 191... OCT 1 1921

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 1921, to Oct 8 1921, that I saw h... alive on Oct 8 1921, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Prematurity of birth,

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

... (Duration) ... yrs. ... mos. ... ds.

(Signed) H Lawrence Kuhn M. D.

Oct 8, 1921. (Address) Lakeland, Ames

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, London Park | DATE OF BURIAL, Oct 10, 191...

20-UNDERTAKER C Schleman | ADDRESS 1139 Ames

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57565

CERTIFICATE OF DEATH.

79 D 57565

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Braddish Ave WARD 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth T Somers

(a) RESIDENCE NO. 1709 Braddish Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Julian J John D Somers

6 DATE OF BIRTH (month, day, and year) July 22 1854

7 AGE	Years	Months	Days
	67	2	

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia Jefferson Co W Va

PARENTS

10 NAME OF FATHER Charles Rockwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia Jefferson Co W Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia Jefferson Co W Va

14 Informant (Address) Miss Ruby Somers 1709 Braddish Ave

15 Filed OCT 9-1921 ROBERT I. KRAUTH Registrar Bureau of Vital Statistics

Calhoun 1333 N Calhoun

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to Oct 7, 1921, that I last saw h alive on Oct 7, 1921, and that death occurred, on the date stated above, at 1130? m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J E W Talbott, M. D.

10/8, 1921 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall Md DATE OF BURIAL Oct 10 21

20 UNDERTAKER Wm Lackey 502 E Baltimore

ADDRESS

CAUSE OF DEATH in plain terms. Name of certificates. See instructions on back of TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57566

CERTIFICATE OF DEATH.

79 D 57566

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 765 W. Lemston ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizah P. Evans

(Residence in Baltimore: No. 834 W. Fayette St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Sea Captain
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Elizah Evans

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs M. P. Holman

(Address) 3540 Gwynn Oak Ave

15- Filed OCT 9-1921 ROBERT F KRAUTER Registrar

CAUSE OF DEATH must be given in all cases. Be particular and give full information. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au- topsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart (Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know any (Duration) yrs. mos. ds.

(Signed) W K Gonce M. D. (Coroner)

Oct 9, 1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Oct 10, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E. Nalton

Spec.- 1-10 21 - M&T - 1500 Blks.

Rizse

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 57567

D 57567

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 Leadhall St., 23 WARD)

2-FULL NAME Emma J Rizse

(a) RESIDENCE NO. 1141 Leadhall ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Emma John B Rizse

6 DATE OF BIRTH (month, day, and year) Feb 17 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Emma A Beecher

(Address) 1141 Leadhall St

15 Filed OCT 8-1921 ROBERT F KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1921, to Oct 8, 1921, that I last saw her alive on Oct 7, 1921, and that death occurred, on the date stated above, at 9 10 a.m.

The CAUSE OF DEATH* was as follows: Acute Cardiac dilatation.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tb

Dreams (duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr J B Rizse M. D.

10/9, 1921 (Address) 1141 Leadhall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leda Hill — DATE OF BURIAL Oct 11 1921

20 UNDERTAKER Wm Cook — ADDRESS 502 E Balto

CAUSE OF DEATH in plain terms, so that it may be classified. Information on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57568 ✓ D 57568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baynes Hospital

REGISTERED NO. 79

CITY OF BALTIMORE: (No. 8 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank (Jacob) Schmidt

(a) RESIDENCE. No. 1726 Towson Place WARD.

(Usual place of abode) Johnson Town.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Annie Smith

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Baynes Hospital (Address) Balto. Md.

15 OCT 9-1921 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1921, to Oct. 7, 1921, that I last saw h[im] alive on Oct. 6, 1921, and that death occurred, on the date stated above, at 6.00 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Diarrhea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) H. Fredericks, M. D.

10/11/21 (Address) Baynes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Holy Cross Hayd Rd — DATE OF BURIAL Oct 10 1921

20 UNDERTAKER William Cook — ADDRESS 502 E. North

Back of certificates. See instructions on back of TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57569 — 104 — D 57569

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2001 N. Payson ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hayden Sylvester Peregoy, Jr.

(Residence in Baltimore: No. 2001 N. Payson St.: X yrs. 7 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) 4" (Day), 1921 (Year)

7-AGE, 4 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... X 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Hayden S. Peregoy

11-BIRTHPLACE OF FATHER (State or Country). Balto. County, Md.

12-MAIDEN NAME OF MOTHER Nebel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. H. Hoffmann, M. D.

(Address) 3402 Walbrook Ave.

15-

Filed OCT 9-1921 ROBT. J. KRAUER Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 7" (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-4-21 A. M. to 10-7-21 P. M.,

that I saw him alive on Oct. 4" 1921,

and that death occurred, on the date stated above, at 10½ P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum with convulsions

..... (Duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Indigestion from bottle feeding

..... (Duration) X yrs. X mos. 14 ds.

(Signed) O. H. Hoffmann M. D.

10-7", 1921 (Address) 3402 Walbrook Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Oct. 10, 1921

20-UNDERTAKER William Cook — ADDRESS 532 E. North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57570

CERTIFICATE OF DEATH.

120 D 57570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N. Fremont ST., 16 WARD)

2-FULL NAME George G. Brown

(a) RESIDENCE NO. 910 N. Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ellen Brown

6 DATE OF BIRTH (month, day, and year): April 7-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of Industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Christian Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Johanna Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary E. Brown

(Address): 910 N. Fremont

15 OCT 9-1921

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 23, 1921, to Oct 7, 1921, that I last saw him alive on Oct 7, 1921, and that death occurred, on the date stated above, at 845 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis + Dropsy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas H. Dubert, M. D.

(Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 10 1921

20 UNDERTAKER: William Cook

ADDRESS: 826 Mar'l

CAUSE OF DEATH IS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

WEISHAAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57571

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

28 D 57571

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 804 N Shriver St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Michael Weishaar

(Residence in Baltimore: No. 804 N. Shriver St. 66 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. January 26, 1858. (Month) (Day) (Year)

7-AGE, 63 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Asyldene Milker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Farmer

9-BIRTHPLACE, (State or Country), Hanover - Pa.

PARENTS.

10-NAME OF FATHER, Joseph Weishaar

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Angeline Reon

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Daughter-in-law

(Address) 804 N. Shriver

15- OCT 9-1921 ROBERT J. KRAUTER

Filed..... 191.. Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Oct 7 1921, that I saw him alive on Oct 7 1921, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Homer C. Ford M. D.

Oct 8, 1921. (Address) 735 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct. 10, 1921
20-UNDERTAKER William Cook	ADDRESS Fox & Nork

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 57572 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57572

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2828 & 6 Clifton Ave 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia R. Gregg

(a) RESIDENCE No. 2828 & 6 Clifton Ave WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos ds. How long in U. S., if of foreign birth 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of John H. Gregg

6 DATE OF BIRTH (month, day, and year): March 12/1865

7 AGE — Years: 56 Months: 6 Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph J. McRichardson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Louise Bilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mr. H. E. Gregg

(Address) 1122 Mulberry St

OCT 9-1921

ROBERT I. KRAUTER

Registrar

Burial Permit Clerk

12 E 25th St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1921, to Oct 7th, 1921, that I last saw h[illegible] alive on Oct 6th, 1921, and that death occurred, on the date stated above, at 12-50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Gall Bladder

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Facts

(Signed) H. A. Faux, M. D.

1086, 19 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem't

DATE OF BURIAL: Oct 10 1921

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Balto

CAUSE OF DEATH to print plainly, in ink or pencil. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57573

CERTIFICATE OF DEATH.

79 D 57573
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 535 N. Wolfe ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Eaglestone

(a) RESIDENCE. No. 535 N. Wolfe ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 10 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of: Catharine Eaglestone

6 DATE OF BIRTH (month, day, and year): Oct. 24-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Chief Clerk 069
(b) General nature of industry, business, or establishment in which employed (or employer): Tax Dept.
(c) Name of employer: Balto. Ind.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Eaglestone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Catharine M. Eaglestone
(Address) 535 N. Wolfe St.

15 FILED OCT 9-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 , 1921 , to Oct 6 , 1921 , that I last saw him alive on Oct 6 , 1921 , and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gurry , M. D.

10/9 , 1921 (Address) 610 N. Howard ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem. — DATE OF BURIAL: Oct. 10th 1921

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans St.

CAUSE OF DEATH in plain terms. Abbreviations not allowed. Indefinite statements insufficient. Every question must be answered. See back of certificates. TION is very important. See instructions on back.

D 57574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57574

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST., W. & WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen McGarrity

(Residence in Baltimore: No. Dickeyville St.; 60 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Gardner

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Owen Mc Garrity

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Katherine Kelly

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Jas Mc Crea

(Address) 2331 W. Fayette St.

15- OCT 9-1921 191... ROBERT J. BRUTER Burial Permit Clerk Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Head by Motor cycle

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Inder M. D.
(Coroner)

10-6 1921. (Address) 4 Cooley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Oct. 10., 1921

20-UNDERTAKER John J Cowan & Son ADDRESS 901 Hollins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57575

CERTIFICATE OF DEATH.

79 D 57575

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1217 S. Decker ave. St.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Duszynski 40

(Residence in Baltimore: No. 1217 S Decker ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	White	Married

6-DATE OF BIRTH, May (Month), (Day) 1861 (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Casomier Duszynski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Kathrine Duszynski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Duszynski

(Address) 1217 S Decker ave

15 OCT 9-1921 Filed ..... 191.... Burial Permit Issued Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

chronic Valvular heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Patrick Grimes M. D. (Coroner)

10/9, 191.. (Address) 800 Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary Cappe Rd	Oct 11, 1921

20-UNDERTAKER	ADDRESS
Wendell Offel & Son	378 N

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57576

CERTIFICATE OF DEATH.

79 D 57576

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Aprt., ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max. Greif,

(a) RESIDENCE. NO. Lake Drive, ST., WARD.

(Usual place of abode) att Co

Length of residence in city or town where death occurred ~~Life time~~ yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura F. Greif,

6 DATE OF BIRTH (month, day, and year) Dec. 30th. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Mnfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER David Greif,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Thalheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant Mrs. N. Gutman

(Address) Riviera Aprt

15 OCT 9-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

CAUSE OF DEATH. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7th. 19 21

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, 19 21, to Oct 7, 19 21,

that I last saw h~~im~~ alive on Oct 7, 19 21,

and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

Arterio-sclerosis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Harry Adler, M. D.

, 19 (Address) 171 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew	Oct. 10th 1921 19
20 UNDERTAKER	ADDRESS
Levi Sondheim	118 W Mad St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57577 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57577

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No St. Agnes' Hospital WARD)

2-FULL NAME Baby Leslie

(a) RESIDENCE. No. St. Agnes' Hospital WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER F. Leslie

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Baltimore

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mr. F. Leslie
(Address) 223 Stark St.

15 Filed OCT 9-1921 19 ROBERT B. FRANTZ Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1921, to Oct. 8, 1921, that I last saw her alive on Oct. 8th, 1921, and that death occurred, on the date stated above, at 1 am

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Caldwell M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 10 1921

20 UNDERTAKER Martin Fahey Son ADDRESS 527 W Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fatal Statistics of Accidents may be found on back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57578

CERTIFICATE OF DEATH.

15 VD 57578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: NO. Lombard & Green ST.: 4 WARD)

2-FULL NAME Baby Mayne

(a) RESIDENCE. NO. Ellicott City ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or 30 min.
	✓	✓	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) University Hospital Baltimore, Md

PARENTS

10 NAME OF FATHER Frank Mayne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lisbon Md.

12 MAIDEN NAME OF MOTHER Alberta Unglesbee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lisbon Md.

14 Informant Nearest Relative Ellicott City Md.
(Address)

15 Filed OCT 9-1921 ROBERT I. GRAFTON Registrar

Burial p. m. Oct 10

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1921, to Oct 9, 1921, that I last saw h[illegible] alive on Oct 9, 1921, and that death occurred, on the date stated above, at 1300 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech Extraction (duration) yrs. mos. 1 ds. 6½ hrs.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Airy — DATE OF BURIAL Oct. 10 1921

20 UNDERTAKER Easton Sons — ADDRESS Elkott City

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57579 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 | D 57579

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fifteen St & Phila Road ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roeberta K Dilbig

(Residence in Baltimore: No. Fifteen St & Phila Road St.; Infl. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, Oct 28th, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 10. mos. 24 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Herman A Dilbig

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary B. Baker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Baker

(Address) Fifteenth & Phila Road

15- OCT 9 - 1921 1921 Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10/7/21, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/5/21 191..., to 10/7/21 191..., that I saw h[illegible] alive on 10/5/21 191..., and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. J. Hartman M. D.

10/8/21, 191... (Address) 941 Gay St Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct 10, 1921

20-UNDERTAKER Geo C. Miller

ADDRESS 2334 Jefferson St

Important. See instructions on back of certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

57588 D 57580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57580

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Blum

(a) RESIDENCE. NO. 2203 E. Fayette ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 7-'16

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Morris Blum

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rosie Bloom 10/9/21

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Morris Blum
(Address) 2203 E. Fayette.

15 OCT 10 1921 ROBERT F. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1921, to Oct. 9, 1921, that I last saw him alive on Oct. 9, 1921, and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, tonsilpharyngeal + laryngeal.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B. Macpowan M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Oct 10 1921
20 UNDERTAKER	ADDRESS
Moy Lerner	1127 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57581 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-154 D 57581

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 7 WARD)

2-FULL NAME William Dawson

(a) RESIDENCE. No. 941 Rutland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed Georgetta Dawson

6 DATE OF BIRTH (month, day, and year) Oct. 18 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rebecca Fernand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Bay View Hosp. records.
(Address)

15 FILED OCT 10 1921 ROBERT J. KRAUTER Registrar

Burial permit Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1921

17 I HEREBY CERTIFY, That I attended deceased from September 13, 1921, to October 7, 1921, that I last saw him alive on October 7, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Deterioration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? None What test confirmed diagnosis? Physical Findings

(Signed) H. H. Smith M. D.

10/8/ 1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Oct 11 1921
20 UNDERTAKER	ADDRESS
Wm Bach	502 E Pratt

TION is very important. See instructions on back of certificates.

Form 8-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57582

CERTIFICATE OF DEATH.

105 D 57582

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Henry [illegible] Stevens

(a) RESIDENCE NO. 2216 Garrison Blvd ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of Mrs. Florence [illegible]

6 DATE OF BIRTH (month, day, and year) May 23-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Fairbanks Scales Baltimore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry [illegible] Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Berg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Florence [illegible] Stevens

(Address) 2216 Garrison Blvd

15 Filed OCT 10 1921 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 4 1921, to Oct 7 1921.

That I last saw him alive on Oct 7 1921

and that death occurred, on the date stated above, at 10:50 a. m.

The CAUSE OF DEATH* was as follows:

OVER

Dysentary

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms,

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 10 1921

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W North Ave

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not parasitic.
Ordinary colitis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57583

CERTIFICATE OF DEATH.

151 D 57583

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dr Timmis

(a) RESIDENCE. NO. 513. N. Kenwood Ave WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 8 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER J. Stewart McGinnis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Co

12 MAIDEN NAME OF MOTHER Dorothy Clark

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country)

14 Informant J. S. McGinnis
(Address) 513 N. Kenwood ave.

15 Filed OCT 10 1921 ROBERT J. BRAUER Registrar
Burial permit issued

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/8/21, 1921, to 10/9/21, 19....., that I last saw him alive on 10/9/21, 19....., and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Widal & Sieges

(Signed) Alf. L Cage, M. D.

, 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive Cem Balto Co.	Oct 10 1921
20 UNDERTAKER	ADDRESS
Wm C Blacke	927 N Broadway

57584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 57584
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1222 W North Ave ST.: 13 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Hadaway

(Residence in Baltimore: No. 1222 W North ave St.: Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: ....., 1..... (Month) (Day) (Year)

7-AGE: 61 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or Country): Baltimore

PARENTS.
10-NAME OF FATHER: aron Hamburger
11-BIRTHPLACE OF FATHER (State or Country): Germy
12-MAIDEN NAME OF MOTHER: amelia Pallark
13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm L Hadaway
(Address) 1222 North Ave

15-
FILED OCT 10 1921 BOEHM & KRAUTER
Burial Permit Issued Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 9, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Valvular disease of Heart
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
....., 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Chester Town Md
DATE OF BURIAL: Oct 10, 1921
20-UNDERTAKER: J. Ahrens & Co
ADDRESS: 16 E Lexington

Cross out all items not important. See instructions on back of certificate.

D 57585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1591 D 57585

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Druid Hill Park St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent A. Connolly

(Residence in Baltimore: No. 3813 Dalrymple Ave. St.: 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, ... Jan. 27, 1890
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..31..yrs. 8..mos. 10..ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Banker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, James Connolly

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Johanna Welch

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elmer Reuling

(Address) 3315 Walbrook Ave.

15- BURIAL PERMIT

Filed OCT 10 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries by motor truck in head.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J. J. Kenney M. D.
(Coroner)

Oct. 9, 1921 (Address) 2202 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 3813 Dalrymple Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	10/10/..., 1921
20-UNDERTAKER	**ADDRESS**
J. J. Young & Sons	1318 Light St

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57586 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57586

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 Foster Ave. St., 76 Ward)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Kunigunda Bretzl

(a) RESIDENCE NO. 319 Foster Ave St., 76 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clemens Bretzl

6 DATE OF BIRTH (month, day, and year) May 29-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Schober

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Michael Bretzl

(Address) 319 Foster Ave

15 FILED OCT 10 1921 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1921

17

I HEREBY CERTIFY, That I attended deceased from 10/5/21, 19 , to 10/7/21, 19

that I last saw h alive on 10/7/21, 19

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. J. McGarrell M. D.

, 19 (Address) 632-5-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Heart Cem. DATE OF BURIAL Oct 10 1921

20 UNDERTAKER Lilly and Zirkin ADDRESS 403 S. Mo Ave

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificates.

TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 57587

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57587

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.. 907 S. Fiest St. ST., 26 WARD)

2-FULL NAME Eva J. Schmitt

(a) RESIDENCE NO. 907 S. Fiest ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schmitt

6 DATE OF BIRTH (month, day, and year) Oct 30-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert Sammeth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Bachman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George Schmitt. (Address) 907 E. Fiest St.

15 DATE RECEIVED OCT 10 1921 ROBERT A. LEAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Oct 7, 1921, that I last saw her alive on Oct 6, 1921, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Insterstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A B Sutton M. D.

10/9/1921 (Address) 315 S Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Oct 11 1921
20 UNDERTAKER Lilly & Son	ADDRESS 403 N. Gay

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57588

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-09 D 57588

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Somerset ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita A Doyle

(a) RESIDENCE. No. 1015 Somerset ST., 10 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph A Doyle

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER Beatrice R Conroy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs Joseph A Doyle
(Address) 1015 Somerset

15 OCT 10 1921 19 Registrar ROBERT L. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 1921, to Oct 9 1921,

that I last saw h[illegible] alive on Oct 9 1921,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B. Fisher, M. D.

, 19 (Address) 830 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 10 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	1201 E Eager st

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57589

CERTIFICATE OF DEATH.

142 D 57589

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4201 Main Avenue ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Fogarty

(a) RESIDENCE. NO. 4201 Main Ave. Forest Park ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 70 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Fogarty

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick B. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Starleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Harry O. Hartzell

(Address) 4201 Main Avenue

15 Filed OCT 10 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 1921, to Oct 6th, 1921, that I last saw h alive on Oct 5th, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. C. Smith M. D.

19 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/10 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

FREDERICK WILLIAM DAMAST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57590

CERTIFICATE OF DEATH.

91-081 D 57590

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3538 York Road ST., 17 WARD)

2-FULL NAME Frederick William Damast

(a) RESIDENCE NO. 3538 York Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna Cecilia Damast

6 DATE OF BIRTH (month, day, and year) Dec 5- 1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
61	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Packer + Shipper

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster industry

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Phillip Damast

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Sophia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Berlin Germany

14 Informant Mrs F. W. Damast.

(Address) 3538 Greenmount Ave.

15 Filed ..... 19 .....

Deputy Registrar.

C 1 101924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1921, to Oct 8th, 1921, that I last saw him alive on Oct 8, 1921, and that death occurred, on the date stated above, at 12.30A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(without hemorrhage)

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Percy T. Hartt. M. D.

, 19 (Address) 1768 Homestead St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	10/11, 19 21
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

TION is very important. See instructions on back of certificates.

Rpmc—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57591

CERTIFICATE OF DEATH

H D 57591

REGISTERED NO.....

1-PLACE OF DEATH South Balto. General Hospital

CITY OF BALTIMORE: (No. ..... ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sarah Kimel

(a) RESIDENCE. NO. 225 S. Bond ST. ..... WARD. Life

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. — 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Max Kimel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Kimel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hospital Records.

15 Filed OCT 10 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1921, to Oct. 9, 1921, that I last saw her alive on Oct. 9, 1921, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of rectum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Earl F. Brown, M. D.

, 19 (Address) South Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 10/10 1921

20 UNDERTAKER Jack Levin — ADDRESS 1411 E. Balto

TION is very important. See instructions on back of certificates.

D 57592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57592

CERTIFICATE OF DEATH.

REGISTERED NO. C 47

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Washington Rd Halton ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Green

(Residence in Baltimore: No. 540 Lambert St.: yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, April (Month) 15 (Day), 1887 (Year)

7-AGE, 34 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver 040
(b) General nature of industry, business, or establishment in which employed (or employer): Express Delfer

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, Luther Green

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Mary Williams

13-BIRTHPLACE OF MOTHER (State or Country), W Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Bishop

(Address) 540 Lambert St.

15- OCT 10 1921 ROBERT J KRAUTER

Filed....., 191.... Registrar of Vital Statistics

CAUSE OF DEATH in plain terms. It may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis.

Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner)

Oct 8, 1921. (Address) 700 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Oct 11 1921
20-UNDERTAKER	ADDRESS
David Earbes	916 Penna ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57593

CERTIFICATE OF DEATH.

28 D 57593

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municip. Tb. Hospital. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David S. Nelson

(a) RESIDENCE. No. 728 Little Geroge ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of ~~[illegible]~~ Lila Nelson

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore,Md.

PARENTS

10 NAME OF FATHER David B. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Anna Savoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital records
(Address)

15 FILED OCT 10 1921 ROBERT J. KRAMER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct.9th, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sep.17th, 1921, to Oct.9th, 1921, that I last saw him alive on Oct.9th, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) xx yrs. 9 mos. xx ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Tb in sputum;X ray

(Signed) Francis L Dalaglacca, M. D.

, 19 (Address) Municipal Tb. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Dem —	Oct 11 21
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Balt

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57594

CERTIFICATE OF DEATH.

104 D 57594

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1909 E. Chase ST.: 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Mildred Hahn

(a) RESIDENCE. No. 1904 E. Chase ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 21st 1921

7 AGE — Years: — Months: 5 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ooo

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Earl G. Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Leipsig Germany

12 MAIDEN NAME OF MOTHER: Charlotte Seitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Earl G. Hahn
(Address): 1904 E. Chase St.

15 OCT 10 1921 ROBERT J. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Oct 7, 1921, that I last saw her alive on Oct 21, 1921, and that death occurred, on the date stated above, at 7 15 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
from Lactose (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Cushane, M. D.

Oct. 19 1921 (Address) 3100 Hayward Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 10th 1921
20 UNDERTAKER	ADDRESS
Frank Lassahn & Sons	Fullerton

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57595 HEALTH DEPARTMENT—CITY OF BALTIMORE 105 D 57595

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 Patapsco ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth A Ehrhart

(Residence in Baltimore: No. 1220 Patapsco St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. 31, 1917
(Month) (Day) (Year)

7-AGE, 4 yrs. 1 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None 800
(b) General nature of industry, business, or establishment in which employed (or employer). —

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. August H Ehrhart

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Catherine Kemper

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Ehrhart

(Address) 1220 Patapsco St

15- FILED OCT 10 1921 ROBERT J KRAUTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 9th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1921, to Oct 9 1921, that I saw h[illegible] alive on Oct 9 1921, and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Accident

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) .....yrs. .....mos. 1 ds.

(Signed) T. J. Campbell M. D.

Oct 10, 1921 (Address) 1644 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross a a Co

DATE OF BURIAL, 10-12, 1921

20-UNDERTAKER E & B Hank

ADDRESS 115 E West St.

Important. See instructions on back of certificate.

Gastro Intestinal Disturbance.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57596 ✓ D 57596

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leslie H. Wood

(a) RESIDENCE. NO. Mt. Airy, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	(Single, Married, Widowed, or Divorced (write the word))
M	Wh	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 6, 1897

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	6	3~~0~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer N.S. Wood (Father) Mt. Airy, Md

9 BIRTHPLACE (city or town) ~~Frederick~~ Mt. Airy, Md
(State or country)

PARENTS

10 NAME OF FATHER N.S. Wood

11 BIRTHPLACE OF FATHER (city or town) New Market Md
(State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Georgia Shipley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co. Md.

14 Informant N.S. Wood
(Address) Mt Airy Md.

15 OCT 10 1921 Registrar ROBERT A KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1921, to Oct. 9, 1921, that I last saw him alive on Oct. 9, 1921, and that death occurred, on the date stated above, at 7.50 p m.

The CAUSE OF DEATH* was as follows:

Endocarditis - Pericarditis - Nephritis -

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Anuria - pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? X-Ray & Laboratory

(Signed) W.C. Caldwell, M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Piney Grove Cemetery Co Md	10-11 1921
20 UNDERTAKER E & B Harle 115 E West St	ADDRESS

Burial permit Oleed

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57597

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57597

CERTIFICATE OF DEATH.

66

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 N. Stricker St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Spaight

(a) RESIDENCE. No. 230 N. Stricker St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Thomas Spaight

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Nicholas Hoffman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth S. Whitney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

11 Informant Nicholas Hoffman
(Address) 230 N. Stricker St.

15 Filed OCT 10 1921 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4th 1921, to Oct 8th 1921, that I last saw h[er] alive on Oct 6th 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. G. Smith, M. D.

1921 (Address) 1182 Calhoun St—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Oct 12th 1921

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W Baltimore St

CAUSE OF DEATH. Instructions on back of certificates. ATTENTION is very important. See instructions on back.

Spec.-1-10-21—M&T—1500 Bks.

151000
D 57598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54
X 92 D 57598

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elbert C. Bransford

(a) RESIDENCE NO. Lumberton, N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 8 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mrs. Annie C. Bransford.

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tobaccanist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Owen C. Bransford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliz. Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant ... (Address) Johns Hopkins Hospital Record

15 Filed OCT 10 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1921, to Oct 7, 1921, that I last saw h[illegible] alive on Oct 7, 1921, and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema.

Lobar pneumonia (right middle lobe)

(duration) yrs. ... mos 2-3 ds.

CONTRIBUTORY (Secondary) Pernicious anaemia

(duration) yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? North Carolina

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) ... M. D.

10-8, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va — DATE OF BURIAL: Oct 10 1921

20 UNDERTAKER: W M Rountree — ADDRESS: 230 N 2nd

TION is very important. See instructions on back of certificates.

D 57599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 79 ✓ D 57599

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U. P. D. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver B. Hentz

(Residence in ~~Baltimore~~ No. Linthna, Md St.: yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, August 4, 1855
(Month) (Day) (Year)

7-AGE, 66 yrs. 5 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Melchior R. Hentz

11-BIRTHPLACE OF FATHER (State or Country) Penna, ~~Carolina Baughm~~

12-MAIDEN NAME OF MOTHER Caroline Baughman

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. C. Hentz

(Address) York, Pa.

15-

OCT 10 1921 191.... ROBERT E KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(angina Pectoris)
(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) ~~Old Age~~
(Duration) 6 mos. ds.

(Signed) A. J. Hennessy M. D.
(Coroner.)

Oct. 9, 1921 (Address) 2802 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death U. P. D. yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Linthna, Md.

Former or usual residence Linthna, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Linthna Md	Oct 12 1921.
20-UNDERTAKER W M Routson	ADDRESS 2238 N Howard

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57600

CERTIFICATE OF DEATH.

43 D 57600

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 W. Fulton Ave. ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Susie Hillary.

(Residence in Baltimore: No. 312 W. Fulton Ave. St.; 15 yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April (Month) 18 (Day), 1870 (Year)

7-AGE, 51 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John A. Hillary

11-BIRTHPLACE OF FATHER (State or Country), Prince Georges Co. Md.

12-MAIDEN NAME OF MOTHER, Susanah Beresford

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore - Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. Edgar Hillary

(Address) 4001 Kathland Ave

15- OCT 10 1921 ROBERT J KRAUTH Registrar of Vital Statistics

Important. See instructions on back of Certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 18 1921, to Oct 7 1921, that I saw h[er] alive on Oct 7 1921, and that death occurred, on the date stated above, at 8 35 P. m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Carcinoma of Left Breast

(Duration) 5 or 6 yrs. — mos. — ds.

(Signed) M Bowman Hood M. D.

Oct 8, 1921. (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 10, 1921

20-UNDERTAKER George J. Smith — ADDRESS 1000 Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57601

CERTIFICATE OF DEATH.

104 D 57601

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 S Washington ST., V WARD)

2-FULL NAME Ryta Rylicki

(a) RESIDENCE NO. 604 S Washington ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Rylicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Cecila Urbanowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Rylicki
(Address) 604 S Washington

15 ROBERT I KRAUTH
Registrar

OCT 10 1921 Social Form 1 Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 19 1, to Oct 9, 19 1, that I last saw h[illegible] alive on Oct 9, 19 1, and that death occurred, on the date stated above, at 230 A m.

The CAUSE OF DEATH* was as follows:

Acute [illegible] Cholera-Infantum

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 6 hours

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2.

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L Valentine M. D.

1924 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 10 1921
UNDERTAKER John M Weber	ADDRESS 1303 Bank St

CAUSES OF DEATH. See instructions on back of certificates. ATION is very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 57602

CERTIFICATE OF DEATH.

D 57602

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3025 Frederick Av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Resident

2-FULL NAME Elizabeth Jane Tudor

(a) RESIDENCE. NO. 3025 Frederick Av ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? 0 yrs. 10 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov. 25 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Edw. Tudor

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lindia C. White

13 BIRTHPLACE OF MOTHER (city or town) Sams Quarters

(State or country) Somerset Co. Md

14 Informant Mrs Lindia C. White-Tudor

(Address) 3025 [illegible] AVENUE

15 OCT 7 1921 [illegible] Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 . 1921 . to Oct 7 . 1921.

that I last saw h alive on Oct 7 . 1921.

and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Oct 7, 1921 (Address) 2680 Western Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 10 1921
20 UNDERTAKER STUART & MOWEN COMPANY (WILLIAM F. WOODEN, Assessor)	ADDRESS 108 W. NORTH AVE

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57603 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57603

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1245 Wall St. 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Parent Henry Fillers Neva Fillers

(a) RESIDENCE. No. 1245 Wall St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: — Months: 9th Fortal — Days: — If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Fillers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Neva Ott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Henry Fillers (Address) 1245 Wall St

15 Filed OCT 10 1921 19 Jeffries Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8. 11.45 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/8, 1921, to 10/8, 1921, that I last saw him alive on 10/8, 1921, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Dystocia, & Exhaustion
Large Infant 14 Lbs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sepsis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. D. Dintingham, M. D.

10/9/21 (Address) 1245 E Dunbar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ger. United Evangelical — DATE OF BURIAL: Oct 10 1921

20 UNDERTAKER: Mrs E Evans & Sons — ADDRESS: 428 N Chas

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57604

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57604

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 S. Duncan ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mock Ward

(a) RESIDENCE. No. 230 S. Duncan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Ward

6 DATE OF BIRTH (month, day, and year) Feb 13-96

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Butler Md

12 MAIDEN NAME OF MOTHER Mary Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Cora Ward
(Address) 230 S. Duncan

15 FILED OCT 10 1921 ROBERT J. KRAUSE Registrar Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924 to Oct 8, 1924, that I last saw h alive on Oct 7, 1924, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Dis + Asthma

Contributory Nephritis (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cancer (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Hist + Clinical

(Signed) H. C. Burgess, M. D.

(Address) 1122 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — DATE OF BURIAL 10/10/24

20 UNDERTAKER John W Henderson — ADDRESS 1503 E Monument

CAUSE OF DEATH in plain terms, so that a Registrar can classify it. If it may be the result of injuries on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57605 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57605

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 123 N Durham St.: 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William b Brendel

(a) RESIDENCE. No. 123 N Durham St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER George Brendel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Rosie Napashi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant George Brendel
(Address) 123 N Durham St

15 OCT 10 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1921, to Oct 10, 1921

that I last saw him alive on Oct 9, 1921,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) ....yrs. ....mos. 17 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Culture test

(Signed) Geo Keller, M. D.

10.10.1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 11 1921
20 UNDERTAKER	ADDRESS
Wendell Ryffel & Son	3731 Fm

...g on back of certificate. TION is very important. See instructions on

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57606
1PLACE OF DEATH

CERTIFICATE OF DEATH.

158 D 57606
REGISTERED No. C.

CITY OF BALTIMORE (No. Foot of Hughes St. ST: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Shaw.

(Residence in Baltimore: No. 208 E. Fort Ave. 26 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, May 7th. 1858, 1
(Month) (Day) (Year)

7-AGE, 63 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Packer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Furniture

9-BIRTHPLACE, (State or Country), England.

PARENTS.

10-NAME OF FATHER, Thomas Shaw.

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Do not know,

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur E. Shaw. (son)

(Address) 1535 N. Wolfe St.

OCT 10 1921 ROBERT J. KRAUTER
Filed....., 191.....
Registrar of Records

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Drowning.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Walter Leonard M. D.
(Coroner.)

Oct. 8 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	10/10/21, 19....
20-UNDERTAKER	ADDRESS
John J. Doherty & Sons	131 S. Light St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57607 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57607

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 N Keyser St.; 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Little

(a) RESIDENCE. NO. 427 N Keyser St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 47 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Harry Little

6 DATE OF BIRTH (month, day, and year): 8/5/1874

7 AGE: Years 47 Months 3 Days 2
If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jos Keates

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Mary Fiess

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry Little
(Address): 427 N Keyser St

15 FILED OCT 10 1921 WILLIAM J. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20 1921, to Oct 8, 1921, that I last saw h alive on Oct 7, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (duration) 10 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Veith M. D.

10/8, 1921 (Address) 936 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Govans Pres. Cem. — DATE OF BURIAL: 10/10/1921

20 UNDERTAKER: John J. Foley & Sons — ADDRESS: 1318 Eutaw St

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57608 ✓

D 57608

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1804 Lower ST., 19 WARD)

2-FULL NAME Harry Chaide

(a) RESIDENCE NO. 1864 Lower ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23 24

7 AGE Years 2 Months Days 17

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Brooklyn (State or country) Baltimore

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Jennie Chaide

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs Harry Mantz

(Address) 1804 Lower.

15 OCT 10 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Oct 8, 1921, that I last saw him alive on Oct 8, 1921, and that death occurred, on the date stated above, at 7.40 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Wallace & Cole, M. D.

, 19 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem. DATE OF BURIAL Oct 10, 21

20 UNDERTAKER A. Jones ADDRESS 207 S Stricker St

CAUSE OF DEATH to be plainly written. Answers on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55 001 D 57609

57609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospitals

CITY OF BALTIMORE: (No. ..... ST. 22 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Chester

(a) RESIDENCE. NO. 831 Plum Alley ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. | How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Moses Chester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Johnson 0,109

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hosp. Records

(Address) .....

15 Filed OCT 10 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-7 1921 to 10-8 1921

that I last saw her alive on 10-8 1921

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy etc

(Signed) Clyde McNeil, M. D.

(Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Milton Dorchester Co Md	Oct 11 1921
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 N Monty

TION is very important. See instructions on back of

57610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57610

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 115 Welcome Alley. ST.: 27 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Smith.(C)

(Residence in Baltimore: No. 115 Welcome Alley St.: 6 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH, Do not know. (Month), (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. ---- mos. ---- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None. (O)
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Smith.(C) son.

(Address) 111 Welcome Alley

15-

Filed ....., 191.... ROBERT J. KRAUTER Clerk.

Burial Permit Issued Registrar.

OCT 10 1921

CAUSE OF DEATH to be plain terms. Avoid use of abbreviations. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th. 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [signature] (Coroner.) M. D.

Oct 8th, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	Oct 10 ....., 19....

20-UNDERTAKER	ADDRESS
J. H. Strauss' Son	108 N. Gay St

Spec.—9-24-14—M. & T.—2000 Bks.

D 57611

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57611

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Powers ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George G. Dunsmore. unknown

(Residence in Baltimore: No. 822 Powers St.; 79 yrs. 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, Sept. (Month) 5 (Day), 1842 (Year)

7-AGE, 79 yrs. 1 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Hampton Va

PARENTS.

10-NAME OF FATHER, John Dunsmore.

11-BIRTHPLACE OF FATHER (State or Country). Scotland.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Scotland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances T. Dunsmore

(Address) 822 Powers St.

15- Filed OCT 10 1921 191.....

ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Oct 10 1921, that I saw h~~im~~ alive on Oct 9 1921, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Duodenal Ulcer

(Duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Arteio Sclerosis

(Duration) yrs. 6 mos. ds.

(Signed) C F Coughlin M. D.

10/10, 1921. (Address) 3901 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, St Marys. Humphreys

DATE OF BURIAL, Oct 12, 1921

20-UNDERTAKER Walter R. McNamee

ADDRESS 80 Wallings

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 57612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57612

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: No. University Hospital ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Delaney

(a) RESIDENCE. No. 2409 Barclay ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Not known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D. C.

PARENTS

10 NAME OF FATHER John N. Delaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER Mary Brogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Univ Hosp records
(Address)

15 Filed OCT 10 1921 ROBERT A. KRAUSE Registrar
Burial Permit Clerk

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1921, to Oct 5, 1921, that I last saw h[illegible]alive on Oct 5, 1921, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Septic meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Abscess, ethmoid and frontal sinuses (duration) yrs. not known mos. ds.

18 Where was disease contracted if not at place of death? 2409 Barclay St.

Did an operation precede death? Yes Date of Oct 5, 1921

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. B. Jones, M. D.

1[illegible] 19 21 (Address) University Hospital, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 11 1921
20 UNDERTAKER	ADDRESS
E. A. Fridfield Jr	301 E 23

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57613

CERTIFICATE OF DEATH.

104 D 57613

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 Abbottson ST.; 9 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Dawn

(Residence in Baltimore: No. 1531 Abbottston St.; ....yrs.,.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 5th (Day), 1920 (Year)

7-AGE, 1 yrs. 1 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, George Dawn.

11-BIRTHPLACE OF FATHER (State or Country). Balto.

12-MAIDEN NAME OF MOTHER Kathrine Bandell.

13-BIRTHPLACE OF MOTHER (State or Country). Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Dawn

(Address) 1531 Abbottston

15- Filed OCT 10 1921 ROBERT A KNOTT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4 1921, to Oct 8 1921, that I saw h.... alive on Oct 7 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Convulsions, supposed caused by Mal Nutrition

Over

(Duration)....yrs. 3 mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) E. H. Duncan M. D.

Oct 8, 1921. (Address) 5106 York Road

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Johns Cem. DATE OF BURIAL, Oct 11, 1921

20-UNDERTAKER, C. A. Rinehardt ADDRESS 501 E 22 St

Important. See instructions on back of Certificate.

Spec.—5-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57614

CERTIFICATE OF DEATH.

91

D 57614

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lucinda Chaney

(a) RESIDENCE. NO. 1523 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life 75 yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 75? Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address)

15 OCT 10 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct, 5, 1921, to Oct 8, 1921, that I last saw her alive on Oct. 8, 1921, and that death occurred, on the date stated above, at 7:35 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 10? ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sign & Symptoms

(Signed) John J. Colvin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mercy Hospital

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 10 1921

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57615

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 24 N. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar S. Elkins

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., N WARD Balto, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Oscar S Elkins

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edga T Rosenbrook Registrar

(Address) US. PHS Hosp. #56 Baltimore Md.

15 Robert P. Harrison, Registrar

10 1921 .19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7, 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 10, 19 21 to Oct 7. 19 21.

that I last saw him alive on Oct 7, 19 21.

and that death occurred, on the date stated above, at 4'35 P.m.

The CAUSE OF DEATH* was as follows:

Peridonitis chronic general tubercular.

June 10, /21 (duration) -- yrs -- mos -- ds.

CONTRIBUTORY (Secondary) ----- -- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

10/7 1921 (Address) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westwoodale W. Va DATE OF BURIAL Octo 1921

20 UNDERTAKER S Jenkinson Bur ADDRESS E Balto Md

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57616 D 57616

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 39 WARD)

2-FULL NAME Samuel R Smith

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., 39 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26 yrs.	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butler
(b) General nature of industry, business, or establishment in which employed (or employer) -----
(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Edgar T Rosenbrock Registrar US. PHS Hosp. #56 Balto, Md.

15 Filed OCT 10 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1921, to Oct 9, 1921.
that I last saw him alive on Oct 9, 1921.
and that death occurred, on the date stated above, at 3'50 P. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary advanced & active

Sept. 19, /21 (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Tuberculous Cystitis.
Sept. 26/21 (duration) - yrs - mos. -- ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of ---
Was there an autopsy? No
What test confirmed diagnosis? Clinic report.

(Signed) Thomas R. Payne, M. D.
Senior Surgeon (R)
10/9. 1921 (Address) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore MC Oct 10 1921

20 UNDERTAKER J Thompson Bro. ADDRESS 127 E Balto St

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57617

CERTIFICATE OF DEATH.

29 D 57617

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Smith

(a) RESIDENCE. No. 3348 Cedar Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Lily

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed OCT 1 0 1921 J. E. Wilkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9 19 21

17

I HEREBY CERTIFY, That I attended deceased from September 5, 19 21, to October 9, 19 21,

that I last saw him alive on October 8, 19 21,

and that death occurred, on the date stated above, at 1:15 A. M.

The CAUSE OF DEATH* was as follows: (7)

Myocardial insufficiency (7)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Clyde E. Reid, M. D.

10/9/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Highland Harford Co Oct 12 1921

20 UNDERTAKER | ADDRESS

Thenowath & Son Edgewood

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57618 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57618

CERTIFICATE OF DEATH.

REGISTERED NO. 61

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 531 E Fort Ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Sylvia Byrd

(a) RESIDENCE. No. 531 E Fort ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 2 Months — Days 20

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General natnre of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Wm E Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Ada A Hicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant Wm E Byrd

(Address) 531 E Fort ave

15 Filed 1 01921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10.10 1921

17 I HEREBY CERTIFY, That I attended deceased from 10.6, 1921, to 10.10, 1921, that I last saw her alive on 10/10, 1921, and that death occurred, on the date stated above, at 2.a m.

The CAUSE OF DEATH* was as follows:

Semtr Pulmd Tuberculosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic (duration) yrs. mos 8 hrs.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L J Burlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mound Olivet Cem

DATE OF BURIAL: Oct 11 1921

20 UNDERTAKER: E Schloman & Son

ADDRESS 1089 Lancaster

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec. 1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57619

D 57619

41

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2610 Shirley Ave ST., 15 WARD)

2-FULL NAME Emma Miller Affle

(a) RESIDENCE NO. 2610 Shirley ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas G. Affle

6 DATE OF BIRTH (month, day, and year) Jan 4, 1827

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
94	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 00

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton, Pa.

PARENTS

10 NAME OF FATHER Jacob Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Jacob Affle 2610 Shirley Ave

15 Filed Oct 10, 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificates. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9- 1921

17 I HEREBY CERTIFY, That I attended deceased from August, 1921, to Oct 9, 1921, that I last saw h[er] alive on Oct 9- 1921, and that death occurred, on the date stated above, at 10 P.M. m.

The CAUSE OF DEATH* was as follows: 1

Carcinoma duodenum

Colon —

(duration) about 6 yrs. mos. — ds.

CONTRIBUTORY (Secondary) Carcinoma Colon —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No, Date of —

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Chas Bruns M. D.

, 19 (Address) 632 Park Ave, Balto —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Pa	Oct 11 1921
20 UNDERTAKER Wm J Kirkwood	ADDRESS Norfolk

D 57620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57620

CERTIFICATE OF DEATH.

168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 905 Leadenhall St. St.: 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Ferguson. (C)

(Residence in Baltimore: No. 905 Leadenhall St. St.: 1 yrs.. -- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored.	Single.

6-DATE OF BIRTH. July 24th. 1904, (Month) (Day) 1 (Year)

7-AGE. 17 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shirt starcher.
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. Walter Ferguson. (C)

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER. Mary F. Smith. (C)

13-BIRTHPLACE OF MOTHER (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Chester. (C) sister.

(Address) 905 Leadenhall St.

15- Oct 11 1921 Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental illuminating gas poisoning.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D. (Coroner.)

Oct. 10., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Milford Caroline Co Va. DATE OF BURIAL, Oct 11, 1921.

20-UNDERTAKER Irvin Robert Adams ADDRESS 1725 Ashland Ave

CAUSE OF DEATH to print legibly. Items 1 to 15 are important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Bks.

B 57621

HEALTH DEPARTMENT—CITY OF BALTIMORE D 57621

CERTIFICATE OF DEATH.

109-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital WARD)

2-FULL NAME Lewis W. Frisby.

(a) RESIDENCE NO. 1402 Jefferson St. City ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Janie Frisby (wife).

6 DATE OF BIRTH (month, day, and year): Feb. 22 1869.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
52	7	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer 063

(b) General nature of Industry, business, or establishment in which employed (or employer): Printer

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. H. Frisby.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Janie Frisby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Johns Hopkins Hospital. (Address): Baltimore. ~~Robert P. Harrison,~~

15 Filed ..... 19 .....

T 10 1921 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Oct 9 1921.

that I last saw him alive on Oct 9, 1921.

and that death occurred, on the date stated above, at 6 25 a.m.

The CAUSE OF DEATH* was as follows:

Post Operative Pneumonia

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) degree Asthma of a number of (duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of Sept. 30 1921

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings.

(Signed) Claude S. Beck, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laural Cemetery

DATE OF BURIAL: Oct 12 1921

20 UNDERTAKER: Mrs R A Elliott

ADDRESS 1125 Eutaw St

CAUSE OF DEATH in plain terms, so that no other cause may be properly substituted. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57622 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57622

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 Cyan St.: 10 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Rodgers

(a) RESIDENCE. No. 735 Cyan St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 23. 1920

7 AGE: Years 1 Months 11 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Clarence Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Birdie Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Birdie Anderson (Address) 735 Cyan St.

15 Robert P. Harrison, Registrar

D 7991 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Oct 9, 1921, that I last saw h[illegible] alive on Oct 9, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Hill M. D.

(Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Oct 11 1921

20 UNDERTAKER: Geo R A Elliott — ADDRESS 1223 Ashland Ave

THON is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57623

CERTIFICATE OF DEATH.

125

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Andrews.

(a) RESIDENCE. NO. 503 W. Saratoga ST., WARD. St. Michaels.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer) Barber

(c) Name of employer Geo Beckman

9 BIRTHPLACE (city or town) (State or country) Hungara

PARENTS

10 NAME OF FATHER Nikolas andrichak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungara

12 MAIDEN NAME OF MOTHER Mary andrichak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungara

14 Informant Thomas Rapp (Address) 502 Saratoga

15 Filed ... 19 ... Robert P. Harrison, Registrar

CT 1 01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-26- 1921, to Oct 9, 1921, that I last saw him alive on Oct 9, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Ruptured urethra

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Urinary Extravasation

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 10-3-21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Ponte, Jr, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 11 1921

20 UNDERTAKER Joseph Abrens

ADDRESS 221 N B Way

CAUSE OF DEATH in plain terms, so that it may be used in the compilation of certificates. TION is very important. See instructions on back of c

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ethology unknown.
No further history

D 57624

Form — 6-9-19 — H. P. Co. — 1000 Blks.

D 57624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 W. Mulberry ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Brooks

(a) RESIDENCE. No. 715 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colrd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov. 1 - 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 041.

(b) General nature of Industry, business, or establishment in which employed (or employer) Worked in Laundry

(c) Name of employer Ehle Laundry. Ellicott City

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jno Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Duckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Maryland

14 Informant Mother (Address) 715 W Mulberry St

15 Filed , 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

T 101921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 , 1921 , to Oct 8th , 1921 , that I last saw her alive on Oct 8th , 1921 , and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) John Granger , M. D.

, 19 (Address) 1007 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Oct 11 1921

20 UNDERTAKER David Eastwood ADDRESS 601 W Lem & ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57625

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 945 E 30th (St.) 10 (Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Sadler

(a) RESIDENCE. No. 1012 Harford Ave (St.) (Ward)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late J Wilson Sadler

6 DATE OF BIRTH (month, day, and year) Sept 25. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Timothy Egan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Bridget Egan

(Address) 1012 Harford Ave

15 Filed Robert F. Harrison, Registrar

01921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8/21 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1921, to Oct 8, 1921, that I last saw h er alive on Oct 8, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Oedema

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension - Cerebral Hemorrhage - Hemoplegia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Hemiplegia

(Signed) J. H. Richard. M. D.

, 19 (Address) 1451 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Oct. 11 1921
20 UNDERTAKER Edmund W Conkelin	ADDRESS 324 E Eager St.

TION is very important. See instructions on back of certificates.

D 57626

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 57626

REGISTERED No. C 29

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 370 S Pulaski St.; 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Brandau

(Residence in Baltimore: No. 370 S. Pulaski St.; 60 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Sept 15th, 1852 (Month) (Day) (Year)

7 AGE: 69 yrs. — 23 mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ———

9 BIRTHPLACE (State or country): St Louis, Mo

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): St Louis, Mo

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): St Louis Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas A Brandau

(Address) 370 S Pulaski St

15 Filed ... 191 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

T 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 7 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 8, 1921, to Oct 7, 1921

that I saw her alive on Oct 7, 1921

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) — yrs. 1 mos. — ds

Contributory (SECONDARY) same

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. M. Kieffer M. D.

Oct 10, 1921 (Address) Mt Lucas Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery DATE OF BURIAL: Oct 11, 1921

20 UNDERTAKER: F. B. Keppler ADDRESS: 2316 Fredk Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Forney.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57627

CERTIFICATE OF DEATH.

D 57627

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., W WARD)

2-FULL NAME John Forney

(a) RESIDENCE. NO. 645 W. Conway ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Forney

6 DATE OF BIRTH (month, day, and year) Apr 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Apr	32	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benj. A. Forney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Kearns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Benj. A. Forney 645 Conway St.

15 OCT 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1921, to Oct 9th, 1921, that I saw him alive on Oct 9th, 1921, and that death occurred, on the date stated above, at 3:07 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

5 weeks
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure
Oedema of Lungs (duration) mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No State of

Was there an autopsy? No

What test confirmed diagnosis? Widal Reaction

(Signed) Nestor de Cardona M. D.

, 19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Oct 12 1921

ADDRESS

20 UNDERTAKER John J. Fields 1200 N Fremont

Burial Permit Issued

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57628

HEALTH DEPARTMENT—CITY OF BALTIMORE

37

D 57628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Fulton Av ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjorie Catherine Healy

(a) RESIDENCE. No. 1717 Fulton Av ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 2, 1921

7 AGE — Years: — Months: 2 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Martin Bernard Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Marjorie C. Dent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charles Co Md

14 Informant Martin Bernard Healy

(Address) 1717 Fulton Av

15 FILED OCT 11 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 10, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1921, to Oct. 10, 1921.

that I last saw her alive on Oct. 9, 1921,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hospital Findings

(Signed) James H. Eichelberger M. D.

10/10, 1921 (Address) 1724 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 11 1921

20 UNDERTAKER: John J. Fields — ADDRESS: 2200 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57629

CERTIFICATE OF DEATH.

1042 D 57629

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 938 N Saratoga ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Gibson

(a) RESIDENCE. No. 938 N Saratoga ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1918

7 AGE: Years | Months 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Lillie Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Lillie Gibson 908 N Saratoga

15 OCT 11 1921 19

ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Oct 10, 1921, that I last saw h... alive on Oct 9, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Woodwood, M. D.

(Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: Oct 12 1921

20 UNDERTAKER: N. K. Brown & Son — ADDRESS: 1011 Monty

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57630

CERTIFICATE OF DEATH.

50-691

D 57630

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Penna Ave 14 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Lipsky

(a) RESIDENCE NO. 1731 Penna. Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Lipsky

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balto St

15 Filed OCT 11 1921 [illegible] KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH must be properly and completely filled in. See instructions on back of certificates. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1921, to Oct 10, 1921.

that I last saw h er alive on Oct 10, 1921.

and that death occurred, on the date stated above, at 6.20 PM.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical Examn.

(Signed) Eugene Hepner, M. D.

, 19 (Address) 803 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	10/11 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D 57631 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57631

CERTIFICATE OF DEATH.

176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 14 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo Vogelstein

(Residence in Baltimore: No. 1935 Madison Ave St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ~~Oct~~ Oct 10 (Month) (Day) 1870 (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~Clerk~~ Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abel Vogelstein

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

OCT 11 1921 [illegible]

Filed ....., 191.... Burial Permit No. [illegible]

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 11 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-7-21 191.., to 10-11 1921, that I saw h[illegible] alive on 10-11 1921, and that death occurred, on the date stated above, at 4.50 A m.

The CAUSE OF DEATH* was as follows:

Bacteriemia

Vasomotor collapse

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy

(Duration) yrs. 6 mos. ds.

(Signed) Louis Jacks M. D.

10-11, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 9 ds. In the State 18 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1935 Madison st

19-PLACE OF BURIAL OR REMOVAL, Workmen Circle Mt Carmel DATE OF BURIAL, 10/10, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57632

CERTIFICATE OF DEATH.

150 D 57632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital. 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Weisman

(a) RESIDENCE. No. 915 Russell ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Weisman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mary Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Louis Weisman
(Address) 915 Russell st

15 OCT 11 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1921, to Sept. 10, 1921, that I last saw h[illegible] alive on Oct. 10, 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Cystic hygroma

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Secondary infection

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Congenital.

Did an operation precede death? yes. Date of Sept. 24, 1921.

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) J. W. Guyton, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western cemetery — DATE OF BURIAL: Oct. 11 1921

20 UNDERTAKER: James Digman & Son — ADDRESS: 1610 S Paca st

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57633

D 57633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklyn Square ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Maney

(a) RESIDENCE NO. 1529 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): August 1899

7 AGE: Years 22 | Months | Days | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Antonia Texas

PARENTS

10 NAME OF FATHER: Ernest Maney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant: Daniel Beckley

(Address) 2432 Eutaw Place

15 Filed OCT 11 1921 [illegible] KRAUTER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1921, to Oct. 11, 1921, that I last saw her alive on Oct 11, 1921, and that death occurred, on the date stated above, at 1.00 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 10, '21

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis M. Tuttle, M. D.

, 19 (Address) Grant & Fayette Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lakeland Florida | DATE OF BURIAL: Oct 11 1921

20 UNDERTAKER: W. M. Cook | ADDRESS: 502 E North Ave

CAUSE OF DEATH must be plainly filled in, and full TRUTH is very important. See instructions on back of certificate.

D 57634 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57634

CERTIFICATE OF DEATH.

28

REGISTERED NO. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 817 Gorsuch St. ST.: 17 WARD)
2-FULL NAME Jack Vaughn
(Residence in Baltimore: No. 817 Gorsuch St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	col'd	Sing'l

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1897 (Year)

7-AGE,	If LESS than 1 day,
24 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). N. C.

PARENTS.

10-NAME OF FATHER, Simpy Vaughn
11-BIRTHPLACE OF FATHER (State or Country). N. C.
12-MAIDEN NAME OF MOTHER Barbara Ruddy
13-BIRTHPLACE OF MOTHER (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Delsie Vaughn
(Address) 817 Gorsuch St.

15- Filed OCT 11 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. T. Hennessy M. D.
(Coroner.)
Oct. 10, 1921 (Address) 2202 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cokesbury M.E. DATE OF BURIAL, Oct 11, 1921
20-UNDERTAKER Edmund Hennessy ADDRESS 1 E. Biddle St

IMPORTANT. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1204 John ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Massey Gardiner

(Residence in Baltimore: No. 1204 John St ..... St.; ..... yrs., ... mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) ~~Single~~ Divorced

6-DATE OF BIRTH, Feb 16, 1860
(Month) (Day) (Year)

7-AGE, 61 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country). St Marys Co Md

PARENTS.

10-NAME OF FATHER, Thos W Gardiner

11-BIRTHPLACE OF FATHER (State or Country) St Marys Co Md

12-MAIDEN NAME OF MOTHER Catherine Askew

13-BIRTHPLACE OF MOTHER (State or Country). St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie M Gardiner

(Address) 1204 John St

15- Filed OCT 11 1921 191.....

ROBERT J KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10", 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1911, to Oct 10" 1921, that I saw h...alive on Oct 2" 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Toxemia due to Malnutrition and Lack of Nourishment

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Henry L Hynson M. D.

Oct 11", 1921. (Address) 1061 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Baltimore

19-PLACE OF BURIAL OR REMOVAL, Norfolk Va — DATE OF BURIAL, Oct 11, 1921

20-UNDERTAKER Robt J Turner & Son — ADDRESS 1424 Pine

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57636

CERTIFICATE OF DEATH.

130 D 57636

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Dolphin St.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Smith

(Residence in Baltimore: No. 622 Dolphin St.; 55 yrs. [illegible] mos. [illegible] ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ~~Oct 10 1866~~ Oct 7 1866
(Month) (Day) (Year)

7-AGE, 55 yrs. [illegible] mos. [illegible] ds.

If LESS than 1 day, [illegible] hrs. or [illegible] min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country) Essex Co. Va.

PARENTS.

10-NAME OF FATHER, Wm A Robinson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm T Smith

(Address) 622 Dolphin

15- OCT 11 1921 ROBERT J. KRAUTER

Filed ....., 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-3-191[illegible], to 10-7-21 191..., that I saw her alive on 10-7-21 191..., and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

1 Asphyxiation from Kerosene

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. N. Bozman M. D.

10/8, 191.. (Address) 1618 Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 11, 1921
20-UNDERTAKER Wm H. Deane Son	ADDRESS 1100 Madison Ave

Important. See instructions on back of certificate.

D 57637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57637

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1505 N. Monroe ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Bamford

(Residence in Baltimore: No. 1505 N. Monroe St.; yrs., 6 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	colored	single

6-DATE OF BIRTH, March 24, 1915. (Month) (Day) (Year)

7-AGE. yrs. 6 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Orphans Home

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Ed. Bamford

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Isabella Shaw

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella Bamford

(Address) 1505 N. Monroe

Filed OCT 11 1921, 191.. ROBERT J. KRAUTH Burial Permit Clerk

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 10, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) us Cirrhosis

(Duration) yrs. 0 mos. ds.

(Signed) J. J. F. Hennessy M. D. (Coroner.)

Oct. 10, 1921 (Address) 782 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Oct. 11, 1921
20-UNDERTAKER Sam'l. H. Chase & Son	ADDRESS 1400 Mosher St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57638

CERTIFICATE OF DEATH.

X 28 D 57638

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501-N-Gilmor ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Mattie Lee Smith

(a) RESIDENCE NO. 501-N-Gilmor ST., 19 WARD Virginia

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 99

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	21	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home. Not employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hookland Co Va.

PARENTS

10 NAME OF FATHER Harry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Clara Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hookland Co

14 Informant Tuffles F Smith.
(Address) 501-N-Gilmor

15 OCT 11 1921 ROBERT I KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 9th 1921, to Oct 10th 1921, that I last saw h... alive on Oct 9th 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

19 (Address) 1618 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Oct 11 1921
20 UNDERTAKER	ADDRESS
Geo W Chase Co	1400 Madison

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57639

D 57639

CERTIFICATE OF DEATH

91

1-PLACE OF DEATH Mr Mwais

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2107 Brenen ST.,75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of John & Era Ramsey.

(a) RESIDENCE. NO. 2107 Brenen ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29th 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2.	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. D.D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Ramsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Era. Greene.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr John Ramsey
(Address) 2107 Brenen St.

15 Filed OCT 11 1921 BOYER & KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1921, to Oct 10, 1921, that I last saw h[illegible] alive on Oct 10, 1921, and that death occurred, on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) none apparent

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. W. Kiefaber M. D.

Oct 10, 1921 (Address) Mineola Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Oct. 12th 1921
20 UNDERTAKER	ADDRESS
J. J. Cowan & Son.	901 Hollins St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57640

CERTIFICATE OF DEATH.

15 D 57640

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital (St.;) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby M Gerrin

(a) RESIDENCE. No. 510 N Kenwood Ave (St.;) E (Ward.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, ... on back of certificates. TION is very important. See instructions on b...

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/8/21

7 AGE: Years ... Months ... Days 3

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER J. Stewart McGinnis

11 BIRTHPLACE OF FATHER (city or town) (State or country) ...

12 MAIDEN NAME OF MOTHER Dorothy L Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ...

14 Informant J. S. McGinnis

(Address) 510 N. Kenwood ave.

15 FILED OCT 11 1921 ROBERT I. KRAUTH Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11/1921

17 I HEREBY CERTIFY, That I attended deceased from 10/8/21, 19..., to 10/11/21, 19..., that I last saw h alive on 10/11/21, 19..., and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Alf. Page, M. D.

, 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olive Cem. Balto. Co.

DATE OF BURIAL: Oct. 11 1921

20 UNDERTAKER: Wm. L. Black

ADDRESS: 927 N. Broadway

Spec. 1-10-21 M&T 1500 Bks.

Lubinski

D 57641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-09 D 57641

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lubinski

(a) RESIDENCE NO. 914 Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7/12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Co.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	5	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Lubinski

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Frances Kelka

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Johns Hopkins Hospital Record
(Address)

15 OCT 11 1921 ROBERT J. KRAUTER Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1921, to 10-10, 1921, that I last saw her alive on 10-10, 1921, and that death occurred, on the date stated above, at 5-15 a m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. 7 mos. 7 weeks ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Emile Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Oct 11 1921
20 UNDERTAKER	ADDRESS
Stephen F. Walkowski	1005 Kenwood

TION is very important. See instructions on back of certificates.

D 57642

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 57642

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2645 Hoger ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Shirley May Henry

(Residence in Baltimore: No. 2646 Hoger St.; yrs., 0 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 29 (Day), 1921 (Year)

7-AGE, yrs. 0 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER, Herbert Henry

11-BIRTHPLACE OF FATHER (State or Country). Balto City

12-MAIDEN NAME OF MOTHER Mildred Yeager

13-BIRTHPLACE OF MOTHER (State or Country). Balto city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mildred Henry

(Address) 2645 Hoger St

15- Filed OCT 11 1921, 191.... Wm Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ....yrs. ....mos. 3 ds.

(Signed) James M Fenton M. D. (Coroner.)

Oct 10, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western

DATE OF BURIAL, Oct 11th, 1921

20-UNDERTAKER Leo G. Cook

ADDRESS Northern Parkway

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57643

CERTIFICATE OF DEATH.

9 | D 57643

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 681 E. Clement ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Catherine Metzger

(a) RESIDENCE. NO. 681 E. Clement ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 26 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Chas. Metzger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER C. Dreese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Chas. Metzger
(Address) 681 Clement St

15 Filed OCT 11 1921 F. H. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/8, 1921, to 10/9, 1921, that I last saw her alive on 10/9, 1921, and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) F. C. Smith M. D.

10/11, 1921 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	Oct. 11 1921
20 UNDERTAKER	ADDRESS
Margaret E. Flynn	1422 Light St.

TION is very important. See instructions on

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No doctor history of
any infection prior

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

63-001

D 57644

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonore Strand.

(a) RESIDENCE. No. 2909 E. Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Robert W. Strand Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Stump. 10/11/21

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant Robert W Strand
(Address) 2909 E. Monument st

15 Filed OCT 11 1921 19 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1921, to Oct 11, 1921, that I last saw her alive on Oct 11, 1921, and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Poliomyelitis (bulbar)
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Respiratory failure
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Spinal fluid.

(Signed) Ella Cowan, M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 12 1921
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Fayette st

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57645

CERTIFICATE OF DEATH.

15 V D 57645

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Granby ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caterina Bruno.

(Residence in Baltimore: No. 909 Granby St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	W	

6-DATE OF BIRTH, 10 — 11 —, 1921.
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, ...hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), City.

PARENTS.

10-NAME OF FATHER, G. Bruno

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Rosa Muzzalio

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Bruno

(Address) 909 Granby St.

15- OCT 11 1921 191.....

ROBERT J. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 — 11 —, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-11-1921, to 10-11 1921, that I saw h.er alive on 10-11 1921, and that death occurred, on the date stated above, at 9.10 A.M.

The CAUSE OF DEATH* was as follows:
Breech presentation
Difficult delivery
.....
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Congenital debility
(Duration) ....yrs. ....mos. ....ds.

(Signed) S. Drummond M. D.

10-11, 1921 (Address) 604 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem.	10/12/21, 191...
20-UNDERTAKER	ADDRESS
G. J. Falvey & Son	1315 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57646

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Eutaw ST.; 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Stewart

(a) RESIDENCE. No. 519 Eutaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Samuel Jones

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Florence Stewart

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

14 Informant Florence Stewart

(Address) 519 Eutaw St

15 Filed ..... 19 .....

1 1 1921

Robert P. Harrison,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Oct 10, 1921, that I last saw h[illegible] alive on Oct 9, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Stanley Straus, M. D.

Oct 10 20 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 12 '21
20 UNDERTAKER David Eaton	ADDRESS 916 Park Ave

TION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57647

150

D 57647

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp - ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Charles O'Brien

(a) RESIDENCE. No. Nursery & Childs Hosp. ST., ... WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 31 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) 225 N. Fremont Ave. Mary Zimmerman

15 Robert F. Harrison, Registrar

11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 - 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 - 1921, to Oct. 11 - 1921, that I last saw him alive on Oct. 11 1921, and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 0 yrs. 6 mos. 10 ds.

CONTRIBUTORY (Secondary) Acute dilatat. of heart.

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Israel J. Zeigler M. D.

, 19 (Address) 2001 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct. 13, 1921

20 UNDERTAKER George J. Smith

ADDRESS 1000 25 Eutaw St

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifiention, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57648

CERTIFICATE OF DEATH.

X 104

REGISTERED NO. 18

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Nursery & Child's Hosp. ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Clark.

(a) RESIDENCE. No. N. & Child's Hosp. WARD. Hagerstown Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 18-'21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Phila., Pa

PARENTS

10 NAME OF FATHER Geo Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER Mary Manarhan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumb. Md

14 Informant (Address) Mrs. George A. Hutton N.C.H. Hospital.

15 Filed 11 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1921, to Oct 10th, 1921, that I last saw h im alive on Oct 10th, 1921, and that death occurred, on the date stated above, at 7:35 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal decomposition

(duration) yrs. 7 mos. 22 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Orval J. Dingler, M. D.

19 (Address) 1062 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 13, 1921

20 UNDERTAKER George J. Smith. ADDRESS 1005 E. 25th St

THION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57649 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57649

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. 1650 Belt Ave. ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Sallie Anne Starn.

(a) RESIDENCE. NO. 1650 Belt Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl. Starn.

6 DATE OF BIRTH (month, day, and year) Mar. 24 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jno. Scott.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary J. Deare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Harrison (Address) 1650 Belt Ave

15 Filed 19 Robert P. Harrison, Registrar

1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/21 19

17 I HEREBY CERTIFY, That I attended deceased from 8/30 1921, to 10/9/21 19, that I last saw h[illegible] alive on 10/9/21 19, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Philip B. Lawlor, M. D.

10/11/1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Oct 12 1921
20 UNDERTAKER	ADDRESS
Mrs J. E. Evans	1428 E. Chase

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 57650 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 57650

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Nursery & Child's Hosp ST.) 18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eddie Delfelder

(a) RESIDENCE. NO. Nursery & Child's Hosp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 OCT 11 1921 Robert F. Harrison, Registrar
. 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10th 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 9th, 1921, to Oct 10th, 1921, that I last saw him alive on Oct 10th, 1921, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil P. Daing Cor, M. D.

, 19 (Address) 1002 E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19

20 UNDERTAKER Commissioner Health, ADDRESS

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Following an attack of Influenza of a short duration

Spec.—1-10-21—M&T—1500 Bks.

D 57651 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57651

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 400 Edwards Ave. (Gorans WARD)

2-FULL NAME Laura J. Ewing

(a) RESIDENCE NO. 400 Edwards ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX [redacted] 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amos H. Ewing

6 DATE OF BIRTH (month, day, and year) Dec 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
[redacted]	66	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co

PARENTS

10 NAME OF FATHER Lullian Ewing
11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md
12 MAIDEN NAME OF MOTHER P. Bowman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Amos H. Ewing
(Address) 400 Edwards Ave Govans

15 Filed ....., 19.... Registrar

7 1921

Robert P. Harrison,
Burial Permit Clerk.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH Oct 10/21

16 DATE OF DEATH (month, day, and year) [redacted] 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1921, to Oct 9, 1921,
that I last saw her alive on Oct 9, 1921,
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:

Tubercular Pneumonia

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 15+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harford Co.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no

(Signed) Ronald T. Abercrombie, M. D.
Oct 10, 1921 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wesley Chapel H.C
DATE OF BURIAL Oct 13 1921

20 UNDERTAKER William [illegible]
ADDRESS 502 E. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57652

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ~~Municipal Hospitals~~ ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph G. Matthews

(a) RESIDENCE. NO. 2204 Poplar Gr ST., WARD.
(Usual place of abode) Baltimore (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret Burson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) Municipal Hospitals

15 Filed 10-7 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 — 11 — 1921

17 I HEREBY CERTIFY, That I attended deceased from 10 — 6 —, 1921, to 10 — 11 —, 1921, that I last saw h. im alive on 10 — 11, 1921, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:
Acute poisoning from alcoholic liquids.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Syphilis, gonorrhea, Chancroid, gangrene of penis, Chronic alcoholism
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann Neo

(Signed) Clyde McNeill, M. D.

10-11-1921 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Oct 13/21

20 UNDERTAKER Wm. Cook.

ADDRESS 502 E. North

TION is very important. See instructions on back of certificates.

D 57653

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64

D 57653

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 301 S. Stricker ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Christina Kittleband

(Residence in Baltimore: No. 301 S. Stricker St ST.: 70 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: March (Month) 19 (Day), 1838 (Year)

7 AGE: 83 yrs. 6 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): (d)

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: John P. Trenlib

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmia Helmuth

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Southcomb

(Address) 301 S. Stricker

15. Filed ....., 191.... Robert P. Harrison, Burial Permit Clerk. REGISTRAR

CT - 71921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 9 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Oct 9 1921, that I saw h-e alive on Oct 9, 1921, and that death occurred, on the date stated above, at 9.45 m. P

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Regular Dctr M. D.

Oct 10, 1921 (Address) 1733 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Oct 11, 1921

20 UNDERTAKER: Harry H. Witz & Co

ADDRESS: 1531 W Lomba...

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Erb

HEALTH DEPARTMENT—CITY OF BALTIMORE

98.010

D 57654

CERTIFICATE OF DEATH.

D 57654

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2511 W Baltimore ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Harry Erb.

(a) RESIDENCE NO. 2511 W Baltimore ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 29/1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Erb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Duce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Gay Erb.
(Address) 2511 W. Baltimore Ave.

15 Filed OCT 12 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to Oct 11, 1921,
that I last saw him alive on Oct 11, 1921,
and that death occurred, on the date stated above, at 11.16 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Franklin L. Erb, M. D.

19 (Address) 330 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Krieders Cem. Westminster — DATE OF BURIAL: Oct 13 1921

20 UNDERTAKER: Josiah Pfyfer — ADDRESS: 1600 W. North Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 57655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 57655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 S. Green ST., 42 WARD)

2-FULL NAME Helen Braker

(a) RESIDENCE No. 508 S. Green ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Cal

5 Single, Married, Widowed, or Divorced, (write the word): Widow -

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Nathaniel Braker

6 DATE OF BIRTH (month, day, and year) ——— 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer): Plain Sewing at home -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Jacksonville Florida

PARENTS

10 NAME OF FATHER Harry Sattimore

11 BIRTHPLACE OF FATHER (city or town) ——— (State or country) Georgia

12 MAIDEN NAME OF MOTHER Francis

13 BIRTHPLACE OF MOTHER (city or town) ——— (State or country) Georgia -

14 Informant Fannie Wallace (Address) 508 S Green St

15 Filed OCT 12 1921 ROBERT I. BRUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 10 1921

17

I HEREBY CERTIFY, That I attended deceased from April, 2, 1921, to Oct, 10, 1921, that I last saw h[illegible] alive on Oct, 9, 1921, and that death occurred, on the date stated above, at 2 a, m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Davis Franklin, M. D.

10/12 1921 (Address) 1112 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M[illegible] Auburn — DATE OF BURIAL: Oct 12 1921

20 UNDERTAKER: Sam[illegible] W. Chase Hon — ADDRESS: Woodmere

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57656

CERTIFICATE OF DEATH.

151 D 57656

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1523 Riggs Ave. St.: 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Pinkney

(a) RESIDENCE. No. 1523 Riggs Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 11-'21

7 AGE	Years	Months	Days	If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 880

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Joseph Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa.

12 MAIDEN NAME OF MOTHER Dora Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md.

14 Informant Dora Pinkney
(Address) 1523 Riggs Ave

15 Filed OCT 12 1921 MOSES I KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11- 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11- 1921, to Oct. 11- 1921, that I last saw h- alive on Oct. 11- 1921, and that death occurred, on the date stated above, at 1-30 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth, about 7 months.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. L. McCarthy, M. D.

Oct 11 1921 (Address) 916 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 12 1921
20 UNDERTAKER	ADDRESS
Sam'l E Chase & Son	1100 Mosher

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57657

CERTIFICATE OF DEATH.

H 0 D 57657

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 w. Fayette St. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie E. Bannon

(a) RESIDENCE. NO..... 704 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Bannon

6 DATE OF BIRTH (month, day, and year) Feb. 2. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	52	8	—	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Henry C. Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary V. Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Charles M. Parks (Address) 627 E. 34th St.

15 OCT 12 1921 ROBERT J. KLAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1921, to Oct. 9, 1921, that I last saw h alive on Oct. 9— 1921 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach and Gall Bladder

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Faudrock M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Oct 12 1921
20 UNDERTAKER W. M. Routson	ADDRESS 2258 W Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Borgman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57658

CERTIFICATE OF DEATH.

28

D 57658

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2246 Mc Elderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Bergman

(a) RESIDENCE. No 2246 Mc Elderry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ — HUSBAND of (or) WIFE of John Bergman

6 DATE OF BIRTH (month, day, and year) Oct. 25th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Ricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Balto.~~ Germany ~~Md.~~

12 MAIDEN NAME OF MOTHER Anna Oversides

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Anna Ricker

(Address) 2246 Mc Elderry St.

15 Filed OCT 12 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from October 7, 1921, to October 10, 1921, that I last saw her alive on October 9, 1921, and that death occurred, on the date stated above, at 3.15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Kidneys & Lungs - Far advanced pulmonary Tuberculosis. Tuberculosis of kidney duration ?

Tbc. of Lungs (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (Tbc).

(duration) — yrs. 1 mo. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. of Sputum + Urine + Tuberculin

(Signed) Louis H. Krumrein, M. D.

, 19 (Address) 722 North Kenwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Oct. 13th 1921

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Heiligenstadt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57659

120 D 57659

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Fremont Ave Sts. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George C. Heiligenstadt

(Residence in Baltimore: No. 1026 Fremont Ave Sts. 49 yrs. 10 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. 5th, 1871. (Month) (Day) (Year)

7-AGE, 49 yrs. 10 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Agent & Adj. (b) General nature of industry, business, or establishment in which employed (or employer) Insurance

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo. C. Heiligenstadt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Greta

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara L. Heiligenstadt

(Address) 1026 Fremont Ave

15- OCT 12 1921 Filed....., 191.... ROBERT J. KRAUTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Monday Oct. 10th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 9th 1921. to Oct 10th 1921. that I saw h alive on Oct 9th 1921. and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

Duration yrs. mos. ds.

(Signed) E. Krug Lake M. D.

Oct 12 1921. (Address) 607 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem.

DATE OF BURIAL, Oct. 12th, 1921.

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St.

Spec.—8-24-14—M. & T.—2000 Bks.

Eckenrode

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57660 ✓ 64 D 57660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lakewood Ave., Lakeland St.; 25th WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Anna Mary Eckenrode

(Residence in Baltimore: No. Lakewood Ave., Lakeland St.; abt 30 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH. February (Month) 2 (Day), 1864 (Year)

7-AGE. 57 yrs. 8 mos. 8 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Bochem, Germany.

PARENTS.

10-NAME OF FATHER. Wilhelm Krampe

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Johanna Diebels

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilhelm H. Eckenrode

(Address) Lakeland

15- OCT 12 1921 Filed....., 191.... ROBERT J. KRAUSE Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1921, to Oct 10 1921, that I saw her alive on Oct 10 1921, and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Cyanosis Epilepsy

(Duration) ..... yrs. 8 mos. 29 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ? yrs. ? mos. ? ds.

(Signed) W. H. Eckenrode Sr. M. D.

Oct 10, 1921 (Address) Lakeland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem.	Oct. 13, 1921
20-UNDERTAKER	**ADDRESS**
F. A. Krause & Son	703 Hanover

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57661

CERTIFICATE OF DEATH

115

D 57661

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos L. Gray.

(a) RESIDENCE No. 3 N. Hill St. St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Gray.

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 021

(b) General nature of industry, business, or establishment in which employed (or employer) Mar

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Heath Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Hamman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sarah Gray (Address) 3 N. Hill St.

15 Filed OCT 12 1921 ROBERT J. FRANCIS Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1921, to Oct 11, 1921, that I last saw him alive on Oct 10, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Multiple liver abscess
acute cholecystitis

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3 N Hill St

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) [illegible] M. D.

10/11, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Vienna Md	Oct 13 1921
20 UNDERTAKER	ADDRESS
F. A. Kramer & Son	703 Hanover

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57662

HEALTH DEPARTMENT—CITY OF BALTIMORE

30 D 57662

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1202 Williams ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes B. Christopher

(a) RESIDENCE. NO. 1202 Williams ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. - mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	-	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenography

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O Bldg. Balto Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel E Christopher

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes N. Shenton

13 BIRTHPLACE OF MOTHER (city or town) Dorchester (State or country) Md

14 Informant Agnes N Christopher
(Address) 1202 Williams st

15 OCT 12 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 21, to Oct 10 21,
that I last saw her alive on Oct 10 21,
and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) ... yrs. ... mos. 25 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. E. Smith, M. D.

(Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct 13/21
20 UNDERTAKER	ADDRESS
John F Denny	715 Light

TION is very important. See instructions on back of certificates.

D 57663

HEALTH DEPARTMENT--CITY OF BALTIMORE

Woolf

CERTIFICATE OF DEATH

D 57663

29

1 PLACE OF DEATH — Registered No. C .....

CITY OF BALTIMORE (No. 2846 Parkwood Ave ST. ... 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Hannah Woolf

(Residence in Baltimore: No. 2846 Parkwood ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: April 1 (Month) (Day), 1849 (Year)

7 AGE: 72 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Lewis Frank

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emily

13 BIRTHPLACE OF MOTHER (State or country): Sarah Stern

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Woolf

(Address) 2200 N Karlt ave

15 Filed OCT 12 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 10 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Oct 10 1921, that I saw h.. alive on Oct 10, 1921, and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(Duration) 10 yrs. mos. ds

Contributory (SECONDARY) Tumor Ida.

(Duration) 6 yrs. mos. ds.

(Signed) Nathaniel Barth M. D.

Oct 11, 1921 (Address) 7731 Parkwood ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Balto Hebrew — DATE OF BURIAL: Oct 13, 1921

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 611 Mad ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57664

CERTIFICATE OF DEATH.

74D 57664

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 862 Vines ST. 18 WARD

2-FULL NAME Richard Allen

(a) RESIDENCE. NO. 862 Vines ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11 '84

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER William Allen

11 BIRTPPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm Allen (Address) 862 Vines St

15 OCT 14 1921 MODE OF DISPOSAL Burial PERMIT Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Oct 11, 1921, that I last saw h alive on Oct 11, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Tetanus (duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Ecclampsia (duration) yrs. mos. 1 hr ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis:

(Signed) J Norwood, M. D.

Oct 14 1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 12 1921
20 UNDERTAKER Brown & Freeland Schrock	ADDRESS 114 W.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Weathely

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57665

CERTIFICATE OF DEATH.

91

D 57665

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 239-Lemly ST (ST.) 18 (WARD)

2-FULL NAME James Weathely

(a) RESIDENCE NO. 200-N-Pamela (ST.) 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) Unemployed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Willie Weathely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mt Airy N C

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Willie Weathely
(Address) 201-N-Pamela St

15 OCT 12 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10- 19.21

17

I HEREBY CERTIFY, That I attended deceased from Oct 4, 1921, to Oct 10, 1921, that I last saw him alive on Oct 4, 1921, and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Walter J Gorsuch M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Oct 12 1921

20 UNDERTAKER Brown & Ireland Co — ADDRESS 114 E. [illegible] St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57666

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 2304 Foster ave ST.: 1st WARD)

2-FULL NAME William H. Johnson

(a) RESIDENCE. NO. 2304 Foster ave ST. 1st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Rogers

6 DATE OF BIRTH (month, day, and year) Apr. 14-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work River Lumberyard

(b) General nature of industry, business, or establishment in which employed (or employer) River Lumberyard

(c) Name of employer Canton Lumber Co

9 BIRTHPLACE (city or town) (State or country) Carroll County Md.

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Addie Johnson (Address) 2304 Foster ave

15 FILED OCT 12 1921 ROBERT J. BRAUER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6 1921, to Oct 10, 1921, that I last saw h... alive on Oct 10 1921, and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Nil

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) O. K. Lutz, M. D.

(Address) 2701 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Oct. 13 1921

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Bolton

TION is very important. See instructions on back of certificates.

Benson.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57667

CERTIFICATE OF DEATH.

79 D 57667

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 W Barre ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda N Benson

(a) RESIDENCE. No. 820 W Barre ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? 37 yrs. 1 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Howard H Benson

6 DATE OF BIRTH (month, day, and year) Sept 5, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Wedderhahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Minnie Heise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Howard H. Benson
(Address) 820 W Barre

15 OCT 12 1921 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1921, to Oct 11, 1921, that I last saw h~~er~~ alive on Oct 11, 1921, and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. 1 yr.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grunbaum, M. D.

10/11, 1921 (Address) 517 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 13 '21
20 UNDERTAKER	ADDRESS
Jandt Wagaman & Son	1002 S. Paca

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57668

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 57668

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarett Hughes

(a) RESIDENCE. No. 4 Dewey Av St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, ~~or divorced~~
HUSBAND of (or ~~WIFE of~~) Alfred Hughes

6 DATE OF BIRTH (month, day, and year) Feb. 1-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harold Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Gaston

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Alfred Hughes
(Address) 4 Dewey av

15 OCT 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Oct 11, 1921, that I last saw h[illegible] alive on Oct 11, 1921, and that death occurred, on the date stated above, at 7 P [illegible] m.

The CAUSE OF DEATH* was as follows:

Peritonitis (Septic)

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Saprasmia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 4 Dewey av

Did an operation precede death? yes Date of Oct 8

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) A B Hughes M. D.

Oct 12 1921 (Address) 1413 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Oct 14 1921
20 UNDERTAKER George A Holland	ADDRESS 1691 Druid Hill Av

TION is very important. See instructions on

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

By phone.

Self induced Abortion

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57669

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Christian St. ST.: 20 WARD)

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Thomas High

(a) RESIDENCE. NO. 2225 Christian St. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 16" 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Edward High

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER Johanna Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Johanna High 2225 Christian St.

15 [illegible] OCT 12 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9" 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to Oct 8—, 1921, that I last saw him alive on Oct 8—, 1921, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease — (Mitral Regurgitation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Hollis Hemming M. D.

Oct 10, 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct. 13" 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Baltimore St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57670

CERTIFICATE OF DEATH.

120 D 57670

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4024 Reliance ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida E. Logan

(a) RESIDENCE. NO. 4024 Reliance ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Andrew Logan

6 DATE OF BIRTH (month, day, and year) Aug 23-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Housework~~ Ooo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Shear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nelson Woodard
(Address) 4024 Reliance

15 OCT 12 1921 ROBERT J. KRAJIEK Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1920, to Oct 10, 1921.

that I last saw her alive on Oct 10, 1921.

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Dilatation Heart

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Walter L Tuckerman M. D.

, 19 (Address) 2332 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Oct 13 1921
20 UNDERTAKER Geo L. Schwab	ADDRESS 2101 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57671

CERTIFICATE OF DEATH.

53 D 57671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3046 E. 22nd (ST.,) 12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Fite

(a) RESIDENCE NO. 304 E 22nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harvey Fite

6 DATE OF BIRTH (month, day, and year): Dec 26 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harvey Fite (Address) 304 E. 22nd St

15 Filed OCT 12 1921 Robert J. Krauter Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1914 to Oct 11 1921, that I last saw her alive on Oct 11 1921, and that death occurred, on the date stated above, at 12-30 P m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) 7 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination Blood

(Signed) Wm H Pearce M. D.

, 19 (Address) 2105 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem.

DATE OF BURIAL: Oct 13 1921

20 UNDERTAKER: W. J. Whetstone

ADDRESS: North Ave

TION is very important. See instructions on back of certificates.

D 57672 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57672

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 932 Greenmount ST. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Travers

(Residence in Baltimore: No. 932 Greenmount St.: yrs., mos. ds.)

1

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE. ....1.... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Bold City

PARENTS.

10-NAME OF FATHER. James Travers

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Blanch Travers

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elias Travers

(Address) 932 Greenmount Ave

15 OCT 12 1921 ROBERT J. KEATER

Filed ..... 191. ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 10 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

..... (Duration) ....yrs. 13 mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

..... (Duration) 1 yrs. 6 mos. ....ds.

(Signed) James H Hanlon M. D.
(Coroner.)

Oct 11, 1921. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, ~~OR REMOVAL~~,	DATE OF BURIAL,
Laurel Md	Oct 12 1921
20-UNDERTAKER	ADDRESS
Earl Hall	115 E. 16 St

CAUSE OF DEATH must be filled in plainly, and in full. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57673 ✓ 172 D 57673

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N. Carolina ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline E Powell

(a) RESIDENCE. NO. 13N N. Carolina ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Thomas Powell

6 DATE OF BIRTH (month, day, and year) Oct 28/1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Gilbert Lowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bristol Pa

12 MAIDEN NAME OF MOTHER Mary Brooz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bristol Pa

14 Informant Mrs E Powell

(Address) 13N N. Carolina st

15 Filed OCT 12 1921 MOSES J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1921, to Oct 10, 1921, that I last saw h~~e~~r alive on Oct 10, 1921 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. " ds.

CONTRIBUTORY (Secondary) Fracture Hip Fall down stairs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) Alvin B Lemmon, M. D.

10/10 1921 (Address) 718 N Fallsway Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	10/13 1921

20 UNDERTAKER	ADDRESS
Chas P. Evans & Son	115 W. Mt Royal ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57674

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 E. 21st ST.: 12 WARD) H1

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Turney

(a) RESIDENCE. NO. 304 E. 21st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? 3 yrs. 9 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widowed

If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of John Turney

6 DATE OF BIRTH (month, day, and year) Nov. 22 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home-wife

(b) General nature of industry, business, or establishment in which employed (or employer): DD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Quebec Canada

PARENTS

10 NAME OF FATHER: John Turney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Quebec Canada

14 Informant: Thomas Turney
(Address) 314 21st

15 Filed OCT 12 1921 ROBERT J. KRAMER Registrar

Permit issued Oct 13

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1920, to Oct. 11, 1921, that I last saw h~~er~~ alive on Oct. 10 1921, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Carcinoma Transverse Colon (duration) yrs. 11 mos. 11 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of Dec. 8, 1920

Was there an autopsy? no.

What test confirmed diagnosis? Clinical observation

(Signed) Thomas J. Galvin M. D.

, 19 (Address) 23 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	10/14 1921

20 UNDERTAKER: Chas. F. Evans & Son ADDRESS 1118 W. Fayette

TION is very important. See instructions on back of certificates.

57675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57675

CERTIFICATE OF DEATH.

175-00 57675

D 57675

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mmersity Hospital St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carmelo Mezzuda

(Residence in Baltimore: No. 342 Whitridge av. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Single

6-DATE OF BIRTH, Augt. (Month) 15 (Day), 1916 (Year)

7-AGE, 5 yrs. / mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Nom - 001
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Saude Mezzuda

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Carmela Zucolo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saude Mezzuda

(Address) 342 Whitridge av

15-

Filed OCT 13 1921 ROBERT J KRAUTH

Burial Permit No. 04668

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries & shock possible fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) struck by Automobile a few hours

(Duration) yrs. mos. ds.

(Signed) W K Gonzales M. D. (Coroner)

10-12, 1921 (Address) 117 N Gaulden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	10/13/21 ID.
20-UNDERTAKER	ADDRESS
Jno J Baker & Son	18 18 Eager

57676 HEALTH DEPARTMENT—CITY OF BALTIMORE 57676

D 57676

CERTIFICATE OF DEATH.

D 57676

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

in Automobile of father

2-FULL NAME Fay Elizabeth Moorefield

(Residence in Baltimore: No. Greensboro N.C. St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH, ..., (Month) (Day) 1 (Year)

7-AGE, ... yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Greensboro N. C.

PARENTS.

10-NAME OF FATHER, Geo Moorefield

11-BIRTHPLACE OF FATHER (State or Country), N C.

12-MAIDEN NAME OF MOTHER, Ruth Pierson

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Moorefield

(Address) —

15- Filed OCT 13 1921 ROBERT J KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Congen. Dilat Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmon embolus

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Ruley M. D. (Coroner)

Oct 12, 1921 (Address) 1057 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Columbus, Ohio — DATE OF BURIAL, Oct. 13th, 1921

20-UNDERTAKER E. J. Fanning & Son — ADDRESS 1938 E. Lafayette Ave.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 57677

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hiant Williams

(a) RESIDENCE. No. 1622 Druid Hill Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred unk yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Widower

5a If married, widowed, or divorced—
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unk na

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk no

12 MAIDEN NAME OF MOTHER Unk na

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Unk no

14 Informant Mrs. Thomas (Address) 1622 Druid Hill ave.

15 Filed ... 19

OCT 13 1921

REGISTRAR & EXECUTIVE

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1921, to Oct 11, 1921, that I last saw him alive on Oct 11 - , 1921, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. J. Wheeler, M. D.

10/12 1921 (Address) 1200 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct 13 1921
20 UNDERTAKER	**ADDRESS**
John H. Tadman	142 N. Hill st

THON is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 W. Lee ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Patterson

(a) RESIDENCE. No. 536 W. Lee ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 9 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Odd)

(b) General nature of indostry, business, or establishment in which employed (or employer) General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Millie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Patterson (Address) 536 W. Hamburg St

15 Filed OCT 13 1921 ROBERT J. KRAUTER Registrar Bur. of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/1921

17 I HEREBY CERTIFY, That I attended deceased from 9/6/21, to 10/10/21, that I last saw him alive on 10/9/21, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

Cont (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J. Fin Brodley, M. D.

15/11/21 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 13 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 W. Hill St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57679 — CERTIFICATE OF DEATH. — 100 ✓ — D 57679

REGISTERED NO. C.....

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St; ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Gannon

(Residence in Baltimore: No. 2009 E. Fairmount Ave St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 10 (Day), 1887 (Year)

7-AGE, 34 yrs. — mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Meter Maker
(b) General nature of industry, business, or establishment in which employed (or employer): C

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Patrick J. Gannon

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Marie Carr

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Gannon

(Address) 539 N. Washington

15- Filed OCT 13 1921 191... ROBERT J. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 11th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 10, 1921, to October 11 1921, that I saw him alive on October 11 1921, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Undetermined — Poliomyelitis

Tonsillectomy & Tuberculosis Glan

Compression (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Charles J. Fay M. D.

10-11-21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem — DATE OF BURIAL, Oct. 17, 1921

20-UNDERTAKER John Slevin & Co — ADDRESS 2005 Eutaw

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57680

CERTIFICATE OF DEATH.

D 57680

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 849 Linden Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Powell

(a) RESIDENCE. No. 849 Linden Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Samuel Powell

6 DATE OF BIRTH (month, day, and year): Unknown 1871

7 AGE: Years 40; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: David Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mc Guyan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sam'l Powell

(Address) 849 Linden ave

15 Filed OCT 13 1921 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to Oct 10, 1921, that I last saw h[er] alive on Oct 10, 1921, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Thyrotoxicosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

10/13, 1921 (Address) 2000 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 17 1921

20 UNDERTAKER: Samuel Hemsley — ADDRESS: Balto

CAUSE OF DEATH in plain terms. No abbreviations or initials. ATION is very important. See instructions on back of certificate.

D 57681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 175 001

D 57681

REGISTERED No. C

1 PLACE OF DEATH Municipal Hospital

CITY OF BALTIMORE (No. Eastern Ave & Road ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna Schmidt.

(Residence in Baltimore: No. Eastern Ave & Taylor Town, Balto Co. St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Single

6-DATE OF BIRTH, July (Month) 6 (Day), 1889 (Year)

7-AGE, 31 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER John Schmidt.

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Margaret Merkel

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Schmidt

(Address) 700 S. 4th St.

15- ROBERT J. KRAUTER

Filed....., 191..... Burial Permit Issued

Registrar.

OCT 13 1921

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigate (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigate (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by automobile driven by some person unknown

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ryan Dooley M. D. (Coroner)

Oct 11, 1921 (Address) 1400 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem	October 13, 1921
20-UNDERTAKER Tully & Feiler	ADDRESS 403 N Gilmor

D 57682

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 57682

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 222 S. Castle ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Mildred Henry

(Residence in Baltimore: No. 222 S. Castle. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug 23rd, 1915
(Month) (Day) (Year)

7-AGE. 7 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: attendant at
(b) General nature of industry, business, or establishment in which employed (or employer): School

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John T. Henry.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Laura A. Slaney

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Henry.

(Address) 222 S. Castle St.

15- OCT 13 1921 191.... ROBERT S KRAUTER Registrar. Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly coded. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) investigation find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Lyon Jones M. D.
(Coroner)

Oct 11, 1921 (Address) 1600 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St. Vincents Cemetery	Oct. 14th, 1921
20-UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Hoyt St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57683

CERTIFICATE OF DEATH.

119 V D 57683

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 S. Fourth St. ST., No WARD)

2-FULL NAME Mary Cotter

(a) RESIDENCE NO. 805 S. Fourth ST., 76 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Patrick Cotter

6 DATE OF BIRTH (month, day, and year) Oct. -1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Conrad Behr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary S. Stockstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Cotter
(Address) 805 S. Fourth St.

15 OCT 13 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1921, to Oct 9, 1921, that I last saw h[illegible] alive on Oct 9, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(duration) yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Neck

(duration) yrs. ..... mos. 2 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Oct 2, 21

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Carl Schmeder, M. D.

10/12 1921 (Address) 340 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Oct 13 1921
20 UNDERTAKER Lilly and Zeller	ADDRESS 403 E Mon[illegible]

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. Do not use abbreviations or symbols. Be sure to answer every question. Information called for on back of certificates. ATTENTION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57684

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 57684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Light St. Ward 23)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E Jefferies

(a) RESIDENCE. No. 912 Light St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 19-1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House at Her

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John H Jefferies

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Schafer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Eva Fisler
(Address) 912 Light st

15 Filed OCT 13 1921 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1920, to Oct 17, 1921, that I last saw her alive on Oct 17, 1921, and that death occurred, on the date stated above, at 5.5 P m.

The CAUSE OF DEATH* was as follows: Bright's disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. E. Speed M. D.

10/13 1921 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 15 1921

20 UNDERTAKER John F Denny — ADDRESS 715 Light

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57685

CERTIFICATE OF DEATH.

64 D 57685

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N. 6th ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Anderson

(a) RESIDENCE. No. 104 N. 6th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances C Anderson

6 DATE OF BIRTH (month, day, and year) Nov 22 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor at odd

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Car Foundry

(c) Name of employer Curtis Bay Md

9 BIRTHPLACE (city or town) (State or country) Prince George Maryland

PARENTS

10 NAME OF FATHER Wm Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER A. Gaither

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Frances C Anderson

(Address) 104 N 6th st Brooklyn Md.

15 Filed OCT 13 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Oct 11, 1921, that I last saw h[illegible] alive on Oct 11, 1921, and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) 3 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O. Brooks, M. D.

, 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Oct 14 1921
20 UNDERTAKER John H Denny	ADDRESS 715 Light St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57686

CERTIFICATE OF DEATH.

80

D 57686

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2449 Laurella ave., St.: 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Virginia Ridenour.

(a) RESIDENCE. No. 2449 Laurella ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sherry C. Ridenour.

6 DATE OF BIRTH (month, day, and year) July 26-1868.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hagerstown. Md.

PARENTS

10 NAME OF FATHER Daniel M. Firth.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Clara M. Embrey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md.

14 Informant Sherry C. Ridenour. (Address) 2449 Laurella ave.

15 Filed OCT 13 1921, 19.. ROBERT P. KRAUSE, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2 - 1921, to Oct. 12 - 1921, that I last saw h[illegible] alive on Oct. 12 - 1921, and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows: Cerebral Embolism.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Interstitial nephritis, Uremia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Lloyd Noble. M. D.

19 (Address) 120 E. Lafayette ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md

DATE OF BURIAL: 10/14 1921

UNDERTAKER: Wm. J. Dickner & Son.

ADDRESS: N. Potomac Ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57687

D 57687

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 27 WARD)

2-FULL NAME Edgar Williams

(a) RESIDENCE. No. 214 Patapsco ave. Pimlico St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse racing 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Henry Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Hospital Records
(Address) M. T. H.

15 Filed OCT 13 1921 19 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1921, to Oct. 11, 1921, that I last saw him alive on Oct. 10, 1921, and that death occurred, on the date stated above, at 4.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.

(Signed) Francis L Dalaglacu, M. D.

10-11-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Evergreen	Oct 13 1921
20 UNDERTAKER	ADDRESS
Geo M. Frutt & Son	811 N Wolfe

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57688

CERTIFICATE OF DEATH.

80 D 57688

1-PLACE OF DEATH 1829 Eutaw Place - Balto Md REGISTERED NO. C

CITY OF BALTIMORE: (NO. ST.; 19 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F Harley

(Residence in Baltimore: No. 1829 Eutaw Place St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, May 10, 1866 (Month) (Day) (Year)

7-AGE. 55 yrs. 5 mos. 1 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). (37)

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Wm. J. Waterman

11-BIRTHPLACE OF FATHER (State or Country). Kentucky

12-MAIDEN NAME OF MOTHER Mary Sidney Winder

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. Harley

(Address) 1829 Eutaw Place

15-

Filed OCT 13 1921 ROBERT F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 11, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1916, to Oct 11 1921, that I saw her alive on Oct 10 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral disease Hypertrophy Cardiac dilatation (Duration) 4 yrs. mos. ds.

(Signed) J. W. A. Fletcher M. D.

Oct 12, 1921 (Address) 1025 Madison Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cem. DATE OF BURIAL. Oct 13, 1921

20-UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57689

CERTIFICATE OF DEATH.

45 D 57689

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Light St. ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evaline C. Knapp

(a) RESIDENCE. No. 1923 Light St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Knapp

6 DATE OF BIRTH (month, day, and year) Dec 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Erie

(State or country) Penna.

PARENTS

10 NAME OF FATHER Wm Crane

11 BIRTHPLACE OF FATHER (city or town) Erie

(State or country) Pa.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14 Informant Wm Knapp

(Address) 1923 Light St

15 Filed OCT 13 1921 ROBERT B KRAETZER Registrar

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. (See reverse side for additional space.) Do not use abbreviations or terms peculiar to physicians. Indefinite or unsatisfactory answers will be returned for correction. Do not report cause of death as "Heart Failure," "Asthenia," "Senility," "Old Age," "Uremia," "Convulsions," "Coma," "Pneumonia," "Septicemia," "Tuberculosis," "Cancer," "Abscess," "Gangrene," "Hemorrhage," "Shock," "Paralysis," "Meningitis," "Tumor," "Internal Injuries," "Accident," "Suicide," "Homicide," "Drowning," "Fracture," "Burns," "Poisoning," "Blood Poisoning," "Infection," "Debility," "Exhaustion," "Cachexia," "Marasmus," "Valvular Disease of the Heart," "Chronic Nephritis," "Kidney Disease," "Liver Disease," "Lung Disease," "Stomach Trouble," "Bowel Trouble," "Childbirth," "Miscarriage," "Abortion," "Still-birth," "Congenital Debility," "Premature Birth," "Malformation," "Monstrosity," "Infancy," "Childhood," "Teething," "Inanition," "Starvation," "Want," "Neglect," "Exposure," "Overdose," "Unknown," "None," "Not Known," "Not Ascertained," "Not Certified," "Not Diagnosed," "Supposed," "Probably," "Apparently," "Presumably," "Perhaps," "Doubtful," "Possibly," "Unascertained," "Undiagnosed," "Undetermined," "Unspecified," "Unavailable," "Unavoidable," "Unnecessary," "Unpreventable," "Unpreventable," "Unpreventable

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57690

CERTIFICATE OF DEATH.

151 D 57690

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Fairmount Av ST.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H Tucker

(Residence in Baltimore: No. 1521 Fairmount Ave St.; ....yrs. ....mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	Col	single

6-DATE OF BIRTH, Oct. (Month) 5 (Day), 1921 (Year).

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 6 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) GOD.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Robert H. Tucker

11-BIRTHPLACE OF FATHER (State or Country), West Indy. Islands

12-MAIDEN NAME OF MOTHER Lucile Scott

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert H. Tucker

(Address) 1521 Fairmount Ave.

15- Filed OCT 13 1921 ROBERT A KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 11 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Jan 19[illegible], to ance 191..., that I saw h... alive on Oct. 8th 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:
Emaciation. He would not take nourishment. His weight was 41 lbs.

(Duration) ....yrs. ....mos. 1a ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J M Hayes M. D.

10/12, 1921 (Address) 513 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cem	Oct 13, 1921
20-UNDERTAKER Thomas F Feeley & Schroeder	ADDRESS 1400

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57691 HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 57691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 703 Bunnecke ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elwood Sanford Baker.

(Residence in Baltimore: No. 703 Bunnecke St.: ....yrs., 2 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 21 (Day), 1921 (Year)

7-AGE, ...yrs., 2 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Sanford Baker

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Jennie Harvey

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Baker

(Address) 703 Bunnecke St

15-

FILED OCT 13 1921 ROBERT A. KRAUTER Registrar

Registrar's Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1921, to Oct 12 1921, that I saw him alive on Oct 11 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Mabel Belt M. D.

Oct 12, 1921 (Address) 1320 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hum[illegible] DATE OF BURIAL, Oct 13 1921

20-UNDERTAKER Chenoweth & Son ADDRESS Chestnut Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57692

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57692

CERTIFICATE OF DEATH.

154

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3724 Elm ave ST., 13 WARD)

2-FULL NAME James x Sykes

(a) RESIDENCE NO. 3724 Elm ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Sykes

6 DATE OF BIRTH (month, day, and year) May 19 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) in Druid Hill Park

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Nathaniel Sykes

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Catherine Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Laura Sykes (Address) 3724 Elm ave

15 OCT 13 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1921, to Oct 11, 1921, that I last saw h alive on Oct 10, 1921, and that death occurred, on the date stated above, at 4.50 A m.

The CAUSE OF DEATH* was as follows:

Paresis - (Progressive) (See remarks)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General Conditions

(Signed) R. L. Norment M. D.

Oct 13 1921 (Address) 3947 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct 14 1921
20 UNDERTAKER	ADDRESS
Ehrenwettstein	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information required by the property on back of certificates. TION is very important. See instructions on back of certificates.

D 57693 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57693

CERTIFICATE OF DEATH.

186

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2733 Lillon ST.; C V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Milkowski

(Residence in Baltimore: No. 2733 Lillon St St.; yrs., 8/ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 19, 1919
(Month) (Day) (Year)

7-AGE, 2 yrs. 7 mos. ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Wojciech Milkowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Katherine Iwaniez

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wojciech Milkowski

(Address) 2733 Lillon St

15- Filed OCT 13 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia by aspiration of food found in larynx

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) ....

(Duration) .... yrs. .... mos. .... ds.

(Signed) Henry L. Diggs M. D.
(Coroner)

10/12, 1921 (Address) Henry L. Diggs

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Oct 13, 1921
20-UNDERTAKER	ADDRESS
Stephen Falkowski	1008 Keverside Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence of deceased is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57694

CERTIFICATE OF DEATH.

40

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N. Luzerne ave. ST.: 6 WARD)

2-FULL NAME Adolphine Bond.

(a) RESIDENCE. NO. 22 N. Luzerne ave ST., 6 WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced: (or) WIFE of: John Nagel

6 DATE OF BIRTH (month, day, and year): Oct 16 1844

7 AGE — Years: 77 — Months: 11 — Days: — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Louis Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Charlotte Brunner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Mary G. Hart.
(Address) 22 N. Luzerne ave.

15 Filed OCT 13 1921 19 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 1921, to Oct 11 1921, that I last saw her alive on Oct 10th 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus.
unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pyloric Stenosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. J. McAvoy, M. D.

10/12/21 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 10/14/21

20 UNDERTAKER: Jos. J. Ider — ADDRESS: 15 N. Luzerne ave.

CAUSE OF DEATH must be filled in, signed and dated. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57695

CERTIFICATE OF DEATH.

150 D 57695

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4123 Falls Road ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mae Young

(a) RESIDENCE. No. 4123 Falls Road ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write this word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 3- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Harry Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Alberta M. Ruby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Harry Young 4123 Falls Road

15 Filed OCT 1, 1921 F. E. Welton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1920, to Oct. 11, 1921, that I last saw her alive on Oct. 11, 1921, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema 4 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Spina Bifida (Hydrocephalus)
(duration) 1 yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Machin, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct. 13 1921
20 UNDERTAKER	ADDRESS
Horace F. Burgee	3631 Falls Rd

CAUSE OF DEATH to be filled in plainly, in ink, or typewritten. Information required on back of certificates. TION is very important. See instructions on back.

D 57696 HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 57696

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE (No. Franklin Square Hospital 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Schalitzky

(Residence in Baltimore: No. 1902 Wilhelm St.; yrs. 80 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 23 (Day), 1841 (Year)

7-AGE, 80 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or ....mln.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ice Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Laundry

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Andrew Schalitzky

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Annie Lang

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Schalitzky

(Address) 1902 Wilhelm St

15 OCT 13 1921 Filed ..... 191.... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

Coronary Embolism Sudden (Duration) yrs. mos. ds.

(Signed) James M. Renton M. D. (Coroner.)

Oct 14 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Oct 15, 1921

20-UNDERTAKER Harry H. Witzky

ADDRESS 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(See Affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57697

CERTIFICATE OF DEATH.

40

D 57697

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2315 Mondawmin Ave., ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Livingston

(Residence in Baltimore: No. 2315 Mondawmin Ave., 32 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	~~Widowed~~ Widow

6-DATE OF BIRTH, Dec. (Month) 3 (Day), 1868 (Year)

7-AGE, 52 yrs. 6 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St.,

15- OCT 13 1921 191.... ROBERT S. BRUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, OCT (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) was find that said deceased came to N.V. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Woodward M. D. (Coroner)

Oct 13 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lehrenbach Bond — DATE OF BURIAL, 19...

20-UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balt

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State of Maryland,

City of Baltimore.

October 15th, 1921

This is to certify that Jack Lewis Personally appeared before me , a Notary Public of the State of Maryland City of Baltimore, and made oath in due form of law that Mrs. Sarah Livingston, who died on October 13th, 1921, is married and not a widow as stated on death certificate

Mrs Burgat

Notary Public

Jack Lewis

1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Polan. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57698

CERTIFICATE OF DEATH.

66 D 57698

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Polan

(a) RESIDENCE. No. 2624 Eutaw ave. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Polan

6 DATE OF BIRTH (month, day, and year) Unknown 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E. Baltimore St.

15 Filed OCT 13 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12th. 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11th. 1921, to Oct. 12th. 1921, that I last saw him alive on Oct. 12th. 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

1 Terminal Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Spastic Paraplegia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Zeizinky, M. D.

10/14 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem

DATE OF BURIAL: 10/13 1921

20 UNDERTAKER: Jack Lewis 1411 E Balto

ADDRESS

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.– 8-24-14—M. & T.—2000 Blks.

D 57699 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57699

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2229 Walbrook ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina B. Ebberts

(Residence in Baltimore: No. 2229 Walbrook ave St.; 63 yrs., 8 mos. 27 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Jan 15, 1858 (Month) (Day) (Year)

7-AGE, 63 yrs. 8 mos. 27 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (none)

9-BIRTHPLACE, (State or Country), Balto City Maryland

PARENTS.

10-NAME OF FATHER, John N. Schaefer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barbara Riedel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John N. Ebberts

(Address) 2140 Penrose ave

15-Filed OCT 13 1921, 191.... ROBERT J. GRAETER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12, 1921. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 1st 1921, to Oct 12th 1921, that I saw her alive on Oct 11 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Above 2 (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. N. Dwyer M. D.

Oct 12, 1921 (Address) 1817 N Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Oct. 15, 1921.

20-UNDERTAKER, Geo. Weber & Son — ADDRESS 2503 Edmondson

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57700 ✓ 40 D 57700

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Infirmary Hospital ST.: 11 WARD)

2-FULL NAME Mr. Thomas Cornelius

(a) RESIDENCE. No. Y.M.C.A. - Franklin St. ST., WARD. Baltimore Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia R. Cornelius

6 DATE OF BIRTH (month, day, and year) March 14, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6.	26	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work House Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) Y. M. C. A.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Rev. Thomas Cornelius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sarah R. Danecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs G. F. Ward (Address) 1516 Ellamont St.

15 Filed 19 Robert P. Harrison, Registrar

31921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 , 1921 , to Oct 10 , 1921 , that I last saw him alive on Oct 9 , 1921 , and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Carcinoma of pancreas &

Metastasis to regional Glands -

(duration) four hours yrs. mos. ds.

CONTRIBUTORY (Secondary) None Directed .

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of Sept 10 1921.

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy.

(Signed) Keith G. Rice , M. D.

, 19 (Address) Church Home & Infirmary Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Oct 14 1921
20 UNDERTAKER	ADDRESS
R. Sander Sons	1710 Eutaw

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57701

CERTIFICATE OF DEATH.

42

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Essex ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida S. Townsend

(Residence in Baltimore: No. 2223 Essex St. 20 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug (Month) 25 (Day) 1855 (Year)

7-AGE, 66 yrs. 1 mos. 17 da.

If LESS than 1 day, ...hrs. or....mtn.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, Geo. Helbert

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. S. Townsend

(Address) 2223 Essex St.

15-

Filed ....., 191.... Robert P. Harrison,

Registrar.

T 131921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Oct 12 1921, that I saw h.. alive on Oct 11 1921, and that death occurred, on the date stated above, at 5.15 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Unknown (Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

..... (Duration)....yrs.....mos.....da.

(Signed) E B Mitchell M. D.

Oct 13..., 1921. (Address) 1711 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Oct 15, 1921

20-UNDERTAKER J. Sander Sons ADDRESS 1710 Madison

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57702

HEALTH DEPARTMENT—CITY OF BALTIMORE

8,089

D 57702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1509 Patapsco (St.:) 23 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Satterfield Jr

(a) RESIDENCE. No. 1509 Patapsco St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3rd 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John W. Satterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co

12 MAIDEN NAME OF MOTHER Nora M. Larrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Worcester Co

14 Informant John W. Satterfield

(Address) 1509 Patapsco St

15 Filed OCT 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Oct 13, 1921, that I last saw him alive on Oct 12, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & Physical

(Signed) Wm. E. Stifler, M. D.

10/13 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Oct 14th 1921
20 UNDERTAKER	ADDRESS
C. Schloman & Son	1303 Hanover

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57703

CERTIFICATE OF DEATH.

REGISTERED NO. 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 83, 32d ave. St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marya Gorska

(a) RESIDENCE. No. 83, 32d Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17-1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Antoni Gorski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catharine Kozlowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Antoni Gorski (Address) 83 32d Ave

15 Filed ..., 19... Registrar

[1921 Robert P. Harrison, Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1921, to Oct 12, 1921, that I last saw h[er] alive on Oct 9, 1921, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) myocarditis Acute Nephritis

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Kutchins, M. D.

10/IX, 19... (Address) 2010 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus'

DATE OF BURIAL Oct 14 1921

20 UNDERTAKER Wm Fialkowski 168

ADDRESS Eastern Ave.

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificates. TION is very important.

D 57704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 5 St. Paul St. WARD)

2 FULL NAME Estee Smiley

(Residence in Baltimore: No. 224 S. Bethel St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1821 D 57704

REGISTERED No. C

14 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, — (Month) — (Day) 1 (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer D40
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country) Eston Shore Md live in Baltimor 14 years

PARENTS.

10-NAME OF FATHER. Peter Smith

11-BIRTHPLACE OF FATHER (State or Country). Eston Shore md

12-MAIDEN NAME OF MOTHER Asenter Smith

13-BIRTHPLACE OF MOTHER (State or Country). Eston Shore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Smith (Wife)

(Address) 919 N Central Ave

15-

Filed Oct 7, 1921 Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by Pistol Shot

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Kelly M. D.
(Coroner.)

10-13-21, 191.. (Address) 7-4-Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Oct 13, 1921

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

(over)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D 57705

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2611 Boone St. WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl C Saunders

(Residence in Baltimore: No. 2611 Boone St, 15 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Female	Col.	Married

6-DATE OF BIRTH, — — , 1 (Month) (Day) (Year)

7-AGE, 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work 03
(b) General nature of industry, business, or establishment in which employed (or employer): House Work

9-BIRTHPLACE, (State or Country) Harrisonburg Va Live in Baltimore 15 Years

PARENTS.

10-NAME OF FATHER, Granderson Saunders

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Fannie Burrell

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Burrell

(Address) 2611 Boone St

15- Robert P. Harrison,

Filed....., 191.... Registrar.

Burial Permit Clerk.

1937

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12, 1937 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said Injury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis probably due to appendicitis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John Sachs M. D. (Coroner.)

10-12-37, 191.. (Address) 948 Hanover,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Dione Lee Gorsuch DATE OF BURIAL, Oct 15, 1937

20-UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

CAUSE OF DEATH is plain terms, so that it may be properly understood. All items are important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

1525 D 57706

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-036 D 57706

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 17 WARD)

2-FULL NAME Jackson Hicks

(a) RESIDENCE NO. 317 E 21½ Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	B.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-5-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 700

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Born in Balt - Md

PARENTS

10 NAME OF FATHER William Hicks

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Jenkins

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Oct 11, 1921,

that I last saw him alive on Oct 11, 1921,

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Rickets

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? ✓

(Signed) Cleaveland Mason, M. D.

10/11. 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Oct 13 1921

20 UNDERTAKER Mrs R A Elliott ADDRESS 1725 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130

D 57707

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 510 Rossiter (St.:) 27 (Ward)

2-FULL NAME Jacob H Aull.

(a) RESIDENCE. (No.) 510 Rossiter St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary E. Aull

6 DATE OF BIRTH (month, day, and year): Sept. 25, 1847

7 AGE — Years: 73 — Months: — Days: 17 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate & Insurance

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Butler Md

PARENTS

10 NAME OF FATHER: Jacob Aull

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Stagar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hubert H. Aull

(Address): 2917 Harford Ave.

15 Filed OCT 13 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1 1918, to Oct. 12 1921, that I last saw h— alive on Oct. 12 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Koons, M. D.

10-13 1921 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Oct 15 1921

20 UNDERTAKER: George J Smith — ADDRESS: 1000 W. Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57708

CERTIFICATE OF DEATH.

45

D 57708

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3817 Park Heights Ave. ST.: 15 WARD)

2-FULL NAME Henrietta A. Staunt

(a) RESIDENCE. No. 3817 Park Heights ST., Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) June 3, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of indostry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. J. McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Arabella Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs. Chas. F. Krastel
(Address) 3817 Park Hts Ave

15 Filed Oct 13 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to Oct. 11, 1921, that I last saw her alive on Oct. 11, 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH was as follows:
Adeno Carcinoma of Bladder

(duration) About 9 mos. — ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy and pathological section

(Signed) Wm R. Johnson, M. D.

10/11, 21 (Address) 3928 Park Hts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Oct. 14, 1921

20 UNDERTAKER: Geo. J. Smith — ADDRESS: 1000 W. Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57709

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Pennsylvania Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Frances Young.

(a) RESIDENCE. No. 3205 Pennsylvania Ave. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Felix Young.

6 DATE OF BIRTH (month, day, and year) Sept. 18-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Mikel Pickard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Elizabeth J. Snellen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Benj. C. Young (Address) 326 Penha Ave

15 Filed ..... 19 Robert P. Harrison, Registrar

CT 1 31921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13th. 1921

17 I HEREBY CERTIFY, That I attended deceased from October 10th, 1921, to Oct 12th, 1921, that I last saw her alive on Oct 12th, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Notice

(Signed) Wm Conrad Bode, M. D.

19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Oct 15 1921
20 UNDERTAKER George J. Smith	ADDRESS 1000 N Fayette St

TION is very important. See instructions on back of certificates.

D 57710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57710

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert L. Rodgers

(Residence in Baltimore: No. 1614 Baker St,

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 18 (Day), 1902 (Year)

7-AGE, 19 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John H. Rodgers

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Clara C. Martins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Rodgers

(Address) 1614 Baker St

15- Robert P. Harrison,

(Date), 191

Burial Permit Clerk Registrar.

OCT 13 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Aortic Aneurism

(Duration) 2 Months

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W K Jacobs M. D. (Coroner)

10-13, 1921 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 15, 1921

20-UNDERTAKER William Cook

ADDRESS 5026 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 57711 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57711

CERTIFICATE OF DEATH.

92-079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reed Lenz

(a) RESIDENCE. No. 3358 Greenmount ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
12	June 12th 1909			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER William Lenz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Hoppe (Address) (3358 Greenmount ave.)

15 Filed 13 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12th, 1921, to Oct 18th, 1921, that I last saw h alive on Oct. 13th, 1921, and that death occurred, on the date stated above, at 5:45A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? (Home-3358 Greenmount ave.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray picture

(Signed) Henry de Landa, M. D.

, 19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 17 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Monument

TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 57712

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57712

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5242 Linden Heights St., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Sowers

(a) RESIDENCE No. 5242 Linden Heights St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Sowers

6 DATE OF BIRTH (month, day, and year): June 3 1875

7 AGE: Years 45; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Ex Home Warren Balto

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Warren Balto Co

PARENTS

10 NAME OF FATHER: T. M. Ford

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Co. Md

12 MAIDEN NAME OF MOTHER: Susan Fisher

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Co Md

14 Informant: William Sowers (Address) 52 x 2 Linden Heights

15 Filed ..., 19... Robert P. Harrison, Registrar

[Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 21 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1921, to Oct 11, 1921, that I last saw h.. alive on Oct 10, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis myocarditis

about 2 yrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage following

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Niblett, M. D.

Oct 11-21, 19 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Poplar Cem. Balto Co Md

DATE OF BURIAL: Oct 14 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of disease is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57713

D 57713

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 E Lombard ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha S Hostack

(a) RESIDENCE. No. 1723 E Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron S Hostack

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry S Hostack
(Address) 1723 E. Lombard st

15 OCT 14 1921 ROBERT P. KRAUTER Registrar
Social Service Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13th, 1921, to Oct 13th, 1921, that I last saw her alive on , 1921, and that death occurred, on the date stated above, at 8.50 P m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wisner, M. D.

10/13 1921 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	10-14 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. STATE CONTAGIOUS DISEASE, IF ANY, PREVAILING IN FAMILY OR HOUSE. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57714

D 57714

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 S. Smallwood ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert S. Lawrenze

(a) RESIDENCE. No. 612 S. Smallwood ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Albert Lawrenze

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Ethel Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant (Address) Albert Lawrenze 612 S. Smallwood St

OCT 14 1921 ROBERT A. ISAACS Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1921, to Oct 12, 1921, that I last saw h... alive on Oct 11, 1921, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms of

(Signed) Edw. T. Callahan, M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 14 1921
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W. Lombard

TION is very important. See instructions on back of certificates.

Gaines

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57715

CERTIFICATE OF DEATH.

5 V

REGISTERED No. C D 57715

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 E. Madison St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Gaines

(Residence in Baltimore: No. 1114 E. Madison St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	col.	Widower

6-DATE OF BIRTH, Oct. (Month) 14 (Day), 1921 (Year)

7-AGE, ...yrs. 2 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter Gaines

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Gaines

(Address) 1114 Madison St

15- Filed OCT 14 1921 ROBERT A. CARTER Registrar.

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. A. Enslow M. D.
(Coroner.)

10-15, 1921 (Address) 705 E

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Oct. 16, 1921

20-UNDERTAKER John W. Henderson ADDRESS 1502 Monument

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57716

CERTIFICATE OF DEATH.

28 D 57716

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1701 N. Spring ST., 8 WARD)

2-FULL NAME Rebecca Jones

(a) RESIDENCE NO. 1701 N. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of disease TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Levi Jones

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years 45 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Frank Craddock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Susanna Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Roxanna Saunders

(Address) 3104 Barclay St.

15 Filed OCT 14 1921 ROBERT J. BRUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1921, to Oct. 12, 1921.

that I last saw h[illegible] alive on Oct 12, 1921,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis?

Indefinite-

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex-

(Signed) D. Garland Emmett M. D.

(Address) 1334 E. 1st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct 14 1921

20 UNDERTAKER Robt. Turner Sr.

ADDRESS 1442 N. Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57717

92-119 D 57717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2808 Harford Ave - ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Bittner Jr -

(a) RESIDENCE. No. 2808 Harford Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elizabeth Grundell

6 DATE OF BIRTH (month, day, and year) Mar 16 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	73	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturer 086

(b) General nature of industry, business, or establishment in which employed (or employer): Builders Supplies

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Bittner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Grundell (Address) 2808 Harford Ave -

15 Filed OCT 14 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 , 1921 , to Oct 13 , 1921 , that I last saw him alive on Oct 12 , 1921 , and that death occurred, on the date stated above, at 3 a- m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) acute Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

19 (Signed) F. S. Kunzer, M. D.

20 , 1921 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 16th 1921

20 UNDERTAKER Philip Herwig ADDRESS 2012 Aliceanna St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. TION is very important. See instructions on back of certificates.

Jos. C. Thomasson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57718

CERTIFICATE OF DEATH.

1591

D 57718

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1412 Gay St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C. Thomasson

(Residence in Baltimore: No. 127 W. 22 St (Or. Yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Widower

6-DATE OF BIRTH Aug. 3, 1872
(Month) (Day) (Year)

7-AGE. 49 yrs. 2 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) P.R.R. Co.

9-BIRTHPLACE. (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. J. A. Thomasson

11-BIRTHPLACE OF FATHER (State or Country). Miss

12-MAIDEN NAME OF MOTHER Lucia Suttag

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lucia Thomasson

(Address) Manassas Va.

15-

Filed OCT 14 1921 191.. ROBERT A KRAUTER Clerk

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by pistol shot (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Duration yrs. mos. ds.

(Signed) W. E. Dooley M. D.
(Coroner)

10-18 1921 (Address) Balto.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Manassas Va. DATE OF BURIAL, Oct. 15, 1921

20-UNDERTAKER A. S. Marshall ADDRESS 3539 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57719

CERTIFICATE OF DEATH.

79 D 57719

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 864 Raborg ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Hopkins

(a) RESIDENCE. No. 864 Raborg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Mar.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella Hopkins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edw Davis
(Address) 864 Raborg

15 OCT 14 1921 BOARD OF HEALTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Oct 13, 1921, that I last saw h alive on Oct 13, 1921, and that death occurred, on the date stated above, at 1330 m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Atheroma (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.
Oct 12 1921 (Address) 904 or Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Oct 16 1921
20 UNDERTAKER	ADDRESS
A. Lee Bromwell	1610 W Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57720

CERTIFICATE OF DEATH.

150

D 57720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Philadelphia (or Ter) ST., 716 (26) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Capobletti

(a) RESIDENCE NO. Philadelphia Ter. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Mazzarina Capobletti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Mary Picca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mazzarina Capobletti

(Address) 716 Philadelphia Ter

15 OCT 14 1921

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Oct 14, 1921

that I last saw him alive on Oct 12, 1921,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Failure of foramen ovale to close.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maxwell Strazer M. D.

Oct 14 21 (Address) 811 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL Oct 14 1921

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 57721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 57721

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S. Clinton ST., 16 WARD)

2-FULL NAME Sarah E. Wood.

(a) RESIDENCE NO. 211 S. Clinton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Wood.

6 DATE OF BIRTH (month, day, and year) Oct- 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware.

PARENTS

10 NAME OF FATHER Elisha Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware.

14 Informant Sarah Wood (Address) 211 S. Clinton St.

15 Filed OCT 14 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to Oct 13, 1921, that I last saw h[illegible] alive on Oct 13, 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Ascending Pulm Oedema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright Judkins, M. D.

10/14 1921 (Address) 3326 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wellington Cemetery Co. Md.	Oct 15 1921
20 UNDERTAKER	ADDRESS
Lilly & Feiler	403 S. Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of DISEASE is very important. See instructions on back of certificates.

D 57722

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57722

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 709 S Rose St.: 1 WARD)

REGISTERED No. C 11

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Puchmowski

(Residence in Baltimore: No. 709 S Rose St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. Accurate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Infant

6-DATE OF BIRTH, July (Month) 16 (Day), 1921 (Year)

7-AGE, ... yrs. 2 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Ignatous Puchmowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Annie Woarsonnah

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ignatous Puchmowski

(Address) 709 S Rose

15- Filed OCT 14 1921, 191 ROBERT J KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epileptiform
Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Marasmus
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Tyler Feemaley M. D.
(Coroner.)

Oct 15, 1921 (Address) 1500 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary Kappe Md	Oct 14 1921
20-UNDERTAKER	ADDRESS
Wendell Diffenderffer Son	37 S Howard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57723

CERTIFICATE OF DEATH.

120 D 57723

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3004 E Baltimore ST., 6 WARD)

2-FULL NAME Patrick J. O'Melia

(a) RESIDENCE No 3004 E Baltimore ST., 6 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary O'Melia

6 DATE OF BIRTH (month, day, and year) Feb 2-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas O'Melia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Durkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary O'Melia
(Address) 3004 E Baltimore St

15 OCT 14 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1921

17 I HEREBY CERTIFY That I attended deceased from May 15, 21, to Oct. 12, 21,
that I last saw h[e] alive on Oct 11, 1921,
and that death occurred, on the date stated above, at 8 Am.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) J. Knox Insley M. D.
10-15-21 (Address) 2538 E. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral bury

DATE OF BURIAL 10-16 1921

20 UNDERTAKER John A. Moran

ADDRESS 3008 E Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important! See instructions on back of certificates.

D 57724

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57724

CERTIFICATE OF DEATH.

X 159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hotel Belvedere ST.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. Hassett

(Residence in Baltimore: No. — St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, About 48 47 — If LESS than 1 day, ...hrs. or....min.?
....yrs....mos....ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Penn'a (Ohio)

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- OCT 14 1921 Filed....., 191.. ROBERT E KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Found Dead Oct 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by pistol shot
Wound in brain
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner)
Oct 14, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Ohio

19-PLACE OF BURIAL OR REMOVAL, Toledo, Ohio — DATE OF BURIAL, Oct. 14, 1921

20-UNDERTAKER Henry W. Maas & Son — ADDRESS 1635 N. Calvert St.

Via Penn. R.R. Frank H. Lentz, Escort, Toledo, Ohio

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last residence of DECEASED is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 57725

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Frederick Ave ST., 20 WARD)

2-FULL NAME John Melvin Jones

(a) RESIDENCE. No. 2332 Frederick Ave ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/11/192

7 AGE: Years — Months — Days 1 (One day) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank M. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER G M Heller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Gertrude M. Jones

(Address) 2332 Frederick Ave

15 Filed OCT 14 1921, 19 — BOBERT J. KEATER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1921

17

I HEREBY CERTIFY, That I attended deceased from 10-11-21, 19, to 10-12, 19 21, that I last saw him alive on Oct 12, 19 21, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6 Months Embryo)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital weakness

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Asa Libbessels, M. D.

(Address) 2565 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 14 1921
20 UNDERTAKER	ADDRESS
Fred B. Wappert	2236 Frederick Ave

TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57726

CERTIFICATE OF DEATH.

X 3 7 D 57726

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola B. Overstreet nee Smallwood.

(a) RESIDENCE. NO. (215 Lafayette) Ave. ST., WARD. Resides Charlestown W Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or (divorced) HUSBAND of (or) WIFE of wife of L. W. Overstreet 10/6/20

6 DATE OF BIRTH (month, day, and year) 1869 12/18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charlestown W. Va.

PARENTS

10 NAME OF FATHER Chas Thomas Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mrs Viola B. Overstreet nee Smallwood Charlestown W Va

15 Filed OCT 14 1921 ROBT. J. KRAUTH Registrar Bur'l Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/1 . 1921 . to 10/14 . 1921 .

that I last saw her alive on 10/14 . 1921 .

and that death occurred, on the date stated above, at 3 30 am.

The CAUSE OF DEATH* was as follows:

Chronic abt endocarditis

Chronic Tuberculosis (Ulcerative)

Bilateral pelvic abscess

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Stomach

Cardiac Decompensation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. D. Douglas M. D.

. 19 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown W Va	Oct 14 1921
20 UNDERTAKER	ADDRESS
Mellaire Cook	502 E North

THION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. Dup of John & Allie Hutton

D57727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D57727

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1008 E Madison ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME x no 11 x Baby Dutton

(a) RESIDENCE. No. 1008 E Madison St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col. ad

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 17 hrs. | Months 1914 | Days Oct 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no

(b) General nature of industry, business, or establishment in which employed (or employer): no

(c) Name of employer: no

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John E Hutton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Allie Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant: Mrs Ollie Dutton (Address) 1008 E. Madison St.

15 Filed OCT 14 1921 19 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Oct 13, 1921, that I last saw h[illegible] alive on Oct 13, 1921, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

General weakness

Physical condition of

Mother Premature Birth

Blue Baby (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

Blue Baby (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo Pall M. D.

19 (Address) 426 E 23rd St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 14 1921
20 UNDERTAKER	ADDRESS
Mrs J. G. Lock	802 Jefferson

TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57728

CERTIFICATE OF DEATH.

150

D 57728

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4611 Harford Rd ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J Seiger

(a) RESIDENCE NO. 4611 Harford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13/21

7 AGE: Years | Months: 2 | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm G Seiger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Clara J Wenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Wm G Seiger

(Address) 4611 Harford Rd

15 OCT 14 1921 ROBERT E LEWIS Registrar of Vital Statistics Burial Permit Clerk

4 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1921

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1921, to October 13, 1921, that I last saw her alive on October 13, 1921, and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Valvular disease of heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at birth

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Young Wathen M. D.

19 (Address) 1 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem't — DATE OF BURIAL: Oct 15 1921

20 UNDERTAKER: Wm Carl 502 E Baltimore — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Reif

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57729

150 D 57729

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST., 8 WARD)

2-FULL NAME Baby Reif

(a) RESIDENCE NO. 1254 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-28-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Reif

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosie Epstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Johns Hopkins Hospital (Address) City

15 OCT 14 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-1 ..., 1921, to 10-13 ..., 1921,

that I last saw h im alive on 10-13 ..., 1921,

and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

Congenital intestinal obstruction (Malformation)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? hospital (J. H. H.)

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Horace G. Stuart, M. D.

10/14, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 10-14 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57730

168-00 D 57730

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Laurens and Carey Streets ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Peter Schmidt

(Residence in Baltimore: No. 311 University Parkway.

34 St.; yrs. 11 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. October 23rd., 1886
(Month) (Day) (Year)

7-AGE. 34 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Manager
(b) General nature of industry, business, or establishment in which employed (or employer). Bakery

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Peter Schmidt

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Min

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Schmidt
(Address) 500 Equitable Building.

15- OCT 14 1921 Filed ROBERT A KRAUTER Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Asphyxiation by gas
(Gas stove)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) accidental
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)
Oct 14, 1921 (Address) 2802 E Monument Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery
DATE OF BURIAL. Oct 14, 1921

20-UNDERTAKER. Jos. L. Cook
ADDRESS 1003 N. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57731 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57731

91-08

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (NO. ..... ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Britton

(a) RESIDENCE. NO. 2031 Penrose Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1848

7 AGE: Years 73; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Bay View Hospital

(Address) Balto Md.

15 OCT 14 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 13 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1921, to Oct. 13, 1921, that I last saw h[illegible] alive on Oct. 13 1921 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

Brain Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith M. D.

10/14 1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salisbury Md

DATE OF BURIAL: Oct 17 1921

20 UNDERTAKER: Geo W Little

ADDRESS 3700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 57732

HEALTH DEPARTMENT—CITY OF BALTIMORE

18 V D 57732

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1159 E Lombard in rear ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Iachetti, Giuseppi

(Residence in Baltimore: No. 1427 Bank St 6 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1888 (Year)

7-AGE, 32 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosalie Isabel Iachetti

(Address) 1800 4 Eagle St

15-

Filed ....., 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk.

OCT 14 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicidal Shooting.
Temporary Vermid as
rogue st. Jones he knew not Swisday
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Gan Smith M. D.
(Coroner.)

10/14, 1921 (Address) 1401 N Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St Stanislaus Cem. DATE OF BURIAL, Oct 15 1921

20-UNDERTAKER J Herzog & Co 1/2 ADDRESS 2008 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57733 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57733

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1521 Belt Ave. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur J. Ogle.

(Residence in Baltimore: No. 1521 Belt Ave. St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, June 14th, 1883. (Month) (Day), 1 (Year)

7-AGE, 38 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hostler. 913
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country), Delaware.

PARENTS.

10-NAME OF FATHER, Alexander Ogle.

11-BIRTHPLACE OF FATHER (State or Country), Delaware.

12-MAIDEN NAME OF MOTHER Elizabeth.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie Ogle. (wife)

(Address) 1521 Belt Ave.

15-

Filed 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13th, 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.

Pulmonary Tuberculosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alton E. Bernhardt M. D. (Coroner.)

Oct. 14., 1921 (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem	10/15, 1921
20-UNDERTAKER	ADDRESS
I. Frew McCully	130 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

41921

D 57734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57734

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 7 Light St. Wharf. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Watson A. Marshall.

(Residence in Baltimore: No. 2505 E. Fayette St. St.: 35 yrs., ------ mos. ------ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, ... July 11th. 1849, 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
72 yrs. 3 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchman. 062
(b) General nature of industry, business, or establishment in which employed (or employer)..... B. C. & A. R. R. Co.

9-BIRTHPLACE, (State or Country), Cambridge, Md.

PARENTS.

10-NAME OF FATHER, John Marshall

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Millie Hubbard.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Emma B. Marshall. (wife)

(Address)..... 2505 E. Fayette St.

15-

Filed ....., 191.....

Registrar.

141921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October 13th. 1921, ..., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an....inquiry.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
inquiry.....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....Cerebral Apoplexy.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

Oct. 14. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cornersville Md.	Oct. 15, 1921
20-UNDERTAKER	ADDRESS
Wm. C. Black	922 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57735 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57735

CERTIFICATE OF DEATH.

175.00

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. St.: 11 WARD) REGISTERED NO. C ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Putney

(Residence in Baltimore: No. 829 Druid Hill Ave St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female	colored	single

6-DATE OF BIRTH, April 22, 1915
(Month) (Day) (Year)

7-AGE, 6 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... student
(b) General nature of industry, business, or establishment in which employed (or employer) ..... HOME

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Frank Putney

11-BIRTHPLACE OF FATHER (State or Country). N. C.

12-MAIDEN NAME OF MOTHER Susie E. Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. Putney

(Address) 829 Druid Hill Ave.

15- Filed ....., 191.... Robert P. Harrison, Registrar.

OCT 15 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Automobile accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

Oct. 13, 1921. (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Md. Gen. Hosp. In the of death ....yrs. ....mos. 6 ds. State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....
In front of 829 Druid Hill Ave

Former or usual residence 829 Druid Hill Ave

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Auburn Cem	Oct 15, 1921.
20-UNDERTAKER John H Owens	ADDRESS 538 Dolphin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57736

CERTIFICATE OF DEATH.

D 57736

REGISTERED No. C 87

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arnold E. Baum.

(Residence in Baltimore: No. 26 E. Hamburg St. St.; 4 yrs., 8 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, January 24th. 1917, 1
(Month) (Day) (Year)

7-AGE, 4 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Theodore Baum.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Edna Gruss.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore Baum. (father)

(Address) 26 E. Hamburg St.

15- Robert P. Harrison,

Filed....., 191..... Registrar.

OCT 15 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Laryngitis.
Oedema of the Glottis.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.

(Signed) H. K. Simmons M. D.
(Coroner.)

Oct. 14., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. 3 hours. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

26 E. Hamburg St.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Oct. 15. 19.21
20-UNDERTAKER	ADDRESS
F. A. Draver & Son	703 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 57737 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57737

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 E 20th St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Barber

(a) RESIDENCE NO. 517 E 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Philip J Barber Sr

6 DATE OF BIRTH (month, day, and year) May 17th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis A.A. Co Md

PARENTS

10 NAME OF FATHER Gideon McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER M. Elizabeth Gorsuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md

14 Informant Thomas C Barber (Address) 517 E 20th St

15 Filed OCT 15 1921, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1921 to October 13, 1921, that I last saw her alive on October 13, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

1 Cirrhosis Kidneys

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 1/2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George W. Hartman, M. D.

(Address) 2211 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Biddison Family Cemetery Gardenville — DATE OF BURIAL Oct 16th 1921

20 UNDERTAKER George Schilling & Sons — ADDRESS 1146 E Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57738 ✓ D 57738

64

D 57738

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST.: 24 WARD)

2-FULL NAME Samuel Bernard Sheffler.

(a) RESIDENCE. NO. 1631 Belt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 58 Months 4 Days 20 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Shepardstown West Virginia

PARENTS

10 NAME OF FATHER: Jerry Sheffler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Annie Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Annie F Sheffler (Address) 1631 Belt ST

15 Filed NOV 15 1921 Robert F. Garrison, Registrar

Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Oct 14, 1921, that I last saw him alive on Oct 14, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac failure (duration) 10 hrs yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) John T Edwards, M. D.

(Address) Mercy Hospital, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edinburg Va

DATE OF BURIAL: Oct 17 1921

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57739

HEALTH DEPARTMENT—CITY OF BALTIMORE

H3 ✓

D 57739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Brehm's Lane near Belair Road 96 ST.; WARD)

2-FULL NAME Mary K Graham

(Residence in Baltimore: No. Brehm Lane St.; yrs., mos. ds.)

-REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-~~SINGLE,~~ MARRIED, ~~WIDOWED, OR DIVORCED.~~ (~~Write the~~ word.) Married

6-DATE OF BIRTH, June (Month) 8 (Day) 1864 (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) 027

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Joseph Kathmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Foner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L Crane

(Address) Gardenville

15-

Filed ~~Robert P~~ Harrison, 191

Registrar.

~~1921~~ Vital Records Dept.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1921, to Oct 14 1921, that I saw h- alive on Oct 13 1921, and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows: Cancer Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm L Crane M. D.

Oct 14, 1921 (Address) 1731 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Oct 17, 1921
20-UNDERTAKER	ADDRESS
Henry Breck Son	1730 E Baltimore

Wilcg

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57740

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) Mercy Hospital (St.:) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Merlin V. Bushman

(a) RESIDENCE. (No.) Chilham Road, Hill Top Park, Md (St.) (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 20 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Bushman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Norbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Records Mercy Hospital

15 Filed Oct 15 1921 Robt P. Harrison Registrar

OCT 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 21, to Oct 15 21, that I last saw him alive on Oct. 15, 21, and that death occurred, on the date stated above, at 4:10 a. m.

The CAUSE OF DEATH was as follows:

Pulmonary Abscess

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Rupture of Pulmonary Abscess (duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) John V. Eyster, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 17 19
20 UNDERTAKER	ADDRESS
Wm. Fahey & Sons	1817 W. Fifth

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57741

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.; 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Winiecki

(a) RESIDENCE. No. 3229 Elliot St St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Winiecki

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Winiecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Municipal Hospital
(Address)

Robert P. Harrison,
Burial Permit Clerk.
Registrar

OCT 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Oct 13, 1921, that I last saw him alive on Oct 13, 1921, and that death occurred, on the date stated above, at 8:10 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Cystic meningitis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? ? (not Autopsy)

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Mencice, M. D.

. 19 (Address) Municipal Hospital per J. A. McKay, M.D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 17 - 1921
20 UNDERTAKER	ADDRESS
Stephen Frankowski	1008 Fleming Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57742 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57742

138

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital
CITY OF BALTIMORE: (No. Lombard & Greene ST.) 18 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ilona Mildred Milburn

(a) RESIDENCE. NO. 1029 W. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced (or) WIFE of George Milburn

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Laurence Malloy
11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Husband (Address) 1029 W. Saratoga St. Balto. Md.

15 Filed Robert P. Harrison, Registrar
CT 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Oct 13, 1921, that I last saw h[er] alive on Oct 13, 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:
Nephritis Toxemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pregnancy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1029 W. Saratoga, St.
Did an operation precede death? No Date of
Was there an autopsy? No. Clinical Findings
What test confirmed diagnosis?
(Signed) J. M. Reese, M. D.
. 19 (Address) University Hospital Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Auburn Cemetery	Oct 16 1921
20 UNDERTAKER James H. Downie	ADDRESS 1310 Greenmount

MAKE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57743

D 57743

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Ettring ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Baptist

(Residence in Baltimore: No. 2308 Ettring St.; 77 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... — (Month) — (Day) 1858 (Year)

7-AGE, 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laundress

9-BIRTHPLACE, (State or Country), Talbot Co. Md

PARENTS.

10-NAME OF FATHER, Henry Roberts

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Charlotte —

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Lee Baptist

(Address)..... 2308 Ettring St.

15- Robert F. Harrison,

Filed OCT 15 1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1921, to Oct 14 1921, that I saw h[illegible] alive on Oct 13th 1921, and that death occurred, on the date stated above, at 1 2 m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

A Coplin (Duration) — yrs. — mos. 6h ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) — yrs. — mos. — ds.

(Signed) Edward [illegible] M. D.

....., 191... (Address) 1324 N. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Lebanon Cemetery	Oct 16..., 1921
20-UNDERTAKER James F. Dewey	ADDRESS 1302 Pennsylvania Ave

important. See instructions on back of certificate.

Spec.—1-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57744

1504 95

D 57744

CERTIFICATE OF DEATH.

40

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 17 WARD)

2-FULL NAME James H Pollard

(a) RESIDENCE NO. 423 N Fremont Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer 085

(b) General nature of industry, business, or establishment in which employed (or employer) [redacted]

(c) Name of employer [redacted]

9 BIRTHPLACE (city or town) (State or country) Barbadoes W.I.

PARENTS

10 NAME OF FATHER James H. Pollard

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Manie ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant Johns Hopkins Hospital (Address) Robert M. Lynn Hospital

15 Filed OCT 13 1921, 19 ..... Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29th, 1921, to Oct 12th, 1921, that I last saw h[illegible] alive on Oct 12th, 1921, and that death occurred, on the date stated above, at 1 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Oct 1 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lawrence Cemetery

DATE OF BURIAL Oct. 16 1921

20 UNDERTAKER James A Dennis

ADDRESS 1303 Eastman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Wood Payment

D 57745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 57745

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2539 Mc Henry ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Gunther

(a) RESIDENCE NO. 2539 Mc Henry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFF of Margaret Gunther

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
82	June	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary W Ritter

(Address) 2539 Mc Henry

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1 1921 to Oct. 14 1921, that I last saw h. alive on Oct 14 1921, and that death occurred, on the date stated above, at (~~time~~) 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Mechanical Old age

apoplectic stroke Senility

about 1½ yrs ago (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? NO

(Signed) Chas. H. Eichert, M. D.

Oct 17 1921 (Address) 1100 W Fay. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem — DATE OF BURIAL Oct 17 1921

20 UNDERTAKER William Cook — ADDRESS 502 E Hatton

OCT 17 1921 Robert F. Harrison, Registrar

Spec.—8-24-14—M. & T.—2000 Bks.

D 57746 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57746

D 57[illegible] CERTIFICATE OF DEATH. X 42 D 57727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Hester B. Stoops.

(Residence in Baltimore: No. R.F.D. #2 Chesterton Rd. St.; 0 yrs., 2 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1875 (Year)

7-AGE, 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home 037
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo. R. Jones

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah C. Starr

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma M. Blakeney

(Address) 1625 E. Oliver St.

15-

OCT 13 1921 ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 17 1921, to October 13 1921, that I saw her alive on October 13 1921, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Carcinoma of Rectum

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY Metastatic

(Secondary) Carcinoma (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis M. Frank M. D.

Oct. 13, 1921 (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Chesterton Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Chestertown, Md.	Oct. 16, 1921
20-UNDERTAKER Wm. Cook,	ADDRESS 507 E. North ave

To Emma Blakeney via Tolchester Steamboat Co.

important. See instructions on back of certificate.

Spec.-1-10-21-M&T-1500 Blks.

D 57747

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 57747

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME Baby Swindish

(a) RESIDENCE NO. Roseville Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred five yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/12/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Reinhold Swindish

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Paule Swindish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed ..... 19 ..... 1858 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-12, 1921, to 10-13, 1921, that I last saw him alive on 10-13, 1921, and that death occurred, on the date stated above, at 6.35 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes -

What test confirmed diagnosis? .....

(Signed) Horace G. Sturmt ..... M. D.

10/13, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 14 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 57748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57748

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1701 Pitcher ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Payne

(a) RESIDENCE NO. 1701 Pitcher ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	20	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore Md

PARENTS

10 NAME OF FATHER John Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Bunyan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant ... (Address) 1701 Pitcher St

15 Filed ... 19 ... Registrar

Robert P. Harrison,

OCT 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1921, to Oct 12, 1921, that I last saw h— alive on Oct 12, 1921, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Phthisis

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) R. Gardner Offutt M. D.

Oct 13 1921 (Address) 1134-20 St Nw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Oct 16 1921

20 UNDERTAKER Wm Robert A Elliott — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57749 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57749

CERTIFICATE OF DEATH. 28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 623 N. Chapel ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie M. Commons

(a) RESIDENCE. NO. 623 N Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 34 yrs | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): born in Balto

PARENTS

10 NAME OF FATHER: Harrison Commons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Martin Commons 217 Mulberry St

15 Filed 19 Robert P. Harrison, Registrar

151921 Burial Permit Clerk.]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26 1921, to Oct 13 1921, that I last saw h alive on Oct 13 1921, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Toxemia (duration) 0 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

10-13-1921 (Address) 1612 E Monument

10-14-21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetary

DATE OF BURIAL: Oct-16 1921

20 UNDERTAKER: Mrs Robert A. Elliott

ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D 57750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1704 D 57750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Lake or nea Roland or Roland Park ST. 27 WARD)

2-FULL NAME Gustavus J Wagner

(a) RESIDENCE NO. Lake or nea Roland Roland Park ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Wagner

6 DATE OF BIRTH (month, day, and year) May 19th 1836

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
85	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work wheelwright 007

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany ?

14 Informant Sarah E Wagner (Address) Lake or Roland Park

15 Filed OCT 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1919, to Oct 14th, 1921.

that I last saw him alive on Oct 14th, 1921,

and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Wm M. Dabney, M. D.

Oct 15th, 1921 (Address) Ruxton Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Green Md — DATE OF BURIAL Oct 16 1921

20 UNDERTAKER Wm Pickerodons — ADDRESS Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57751

CERTIFICATE OF DEATH.

120

D 57751

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Ramsay St ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs John Rippel

(a) RESIDENCE. No. 2021 Ramsay ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa J. Rippel

6 DATE OF BIRTH (month, day, and year) Aug 3 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Conrad Rippel

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Loffler

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Louisa J. Rippel
(Address) 2021 Ramsay St.

15 Filed OCT 15 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Oct. 13, 1921, that I last saw him alive on Oct 12, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary, Blood, Blood Pressure

(Signed) Edgar E. Tavares, M. D.

19 (Address) 520 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	19
20 UNDERTAKER	ADDRESS
J B Kappert	2336 Fred'k Oct 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57752

CERTIFICATE OF DEATH.

74 D 57752

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mc Dowell

(a) RESIDENCE NO. 709 N. Luzerne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Co.

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/27/1864

7 AGE Years 57 Months ? Days ? If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant John Hopkins Hospital (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1921

17

I HEREBY CERTIFY, That I attended deceased from 9-23 , 1921 , to 10-13 , 1921 ,

that I last saw h in alive on Oct. 13 th , 1921 ,

and that death occurred, on the date stated above, at 6.45 p m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 9/24/21 10/10/21

Was there an autopsy? yes (Hand

What test confirmed diagnosis?

(Signed) F. L. Reichert , M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cem

DATE OF BURIAL Oct 15 1921

20 UNDERTAKER Robt F Harrison, Sr

ADDRESS 1424 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57753

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: | | WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Heller

(a) RESIDENCE. No. 2203 Roslyn ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4hrs mos. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 1921

7 AGE — Years — Months — Days — If LESS than 1 day, 4 hrs. 43 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Columbus Joseph Heller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Miriam Van Sant.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Mrs. Miriam Heller
(Address) 2203 Roslyn Ave.

15 Filed Robert P. Harrison,
Registrar
Burial Permit Clerk.

15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14 . 1921 . to Oct 14 . 1921 .
that I last saw her alive on Oct 14 1921 .
and that death occurred, on the date stated above, at 10 45 P. m.
The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 4hrs. ds.

CONTRIBUTORY (Secondary) Nephritis toxemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Examination

What test confirmed diagnosis?

(Signed) Stanley W. Matthews . M. D.

. 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 15 21
20 UNDERTAKER	ADDRESS
George Heid	1000 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57754

CERTIFICATE OF DEATH.

104 D 57754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 859 Lemon ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Mariano

(a) RESIDENCE NO. 859 Lemon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	1	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Leon Mariano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastman Georgia

12 MAIDEN NAME OF MOTHER Matilda Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastman Georgia

14 Informant (Address) Leon Mariano 859 Lemon st

15 Filed OCT 16 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15 1921

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1921, to October 15, 1921, that I last saw her alive on October 14, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH was as follows:

Convulsions & Indigestion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Indigestion & Convulsions (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. H. W. Kennard M. D.

10-15-1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Auburn Cem.	Oct 16 1921
20 UNDERTAKER	ADDRESS
Jas. Wm. Skinner	1625 E. Mad. st

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"): *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal Indigestion

Gastro Enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57755

CERTIFICATE OF DEATH.

137 D 57755

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1651 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Elizabeth Waters

(a) RESIDENCE. No. 1651 E. Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occ... 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	18	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Atlantic City N.J.
(State or country)

PARENTS

10 NAME OF FATHER Robert H. Waters

11 BIRTHPLACE OF FATHER (city or town) Salisbury Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) Wilmington N.C.
(State or country)

14 Informant Gladys M. Waters Sister.
(Address) 1651 E Monument St

15 OCT 16 1921 ROBERT J. KRAUTER Registrar
Board of Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1921, to 10/14, 1921, that I last saw her alive on 10/14, 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) ...yrs. ...mos. 8 ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Ralph T. Young, M. D.

, 19 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Oct 17 1921

20 UNDERTAKER ADDRESS

Jos. S. Sacks 1302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57756

HEALTH DEPARTMENT—CITY OF BALTIMORE

K 123 D 57756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. 626 ST.: (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Goldberg

(a) RESIDENCE. NO. Ellicott City Md ST.. WARD. Ellicott City Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Goldberg

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J Lewis (Address) 1411 E Baltimore

15 Filed OCT 16 1921 ROBERT A KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 1921

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1921, to October 16, 1921, that I last saw her alive on October 16, 1921, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Perirenal Abcess (2a-1)

Renal Calculi (2a-1)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Renal Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? Yes Date of October 6, 1921

Was there an autopsy? No

What test confirmed diagnosis? (?)

(Signed) Cayetano Panettiere M. D.

10/16/21 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	10/16 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersity Hospital St. 18 WARD)

2-FULL NAME Helen Shapiro

(Residence in Baltimore: No. 865 Hollins st.

REGISTERED No. C 17001 D 57757

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 7, 1918
(Month) (Day) (Year)

7-AGE, 3 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Balt City.

PARENTS.

10-NAME OF FATHER, Paul Shapiro

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Celia Blumberg

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balto St

15- FILED OCT 16 1921, 191... ROBERT J. KRAUTER Registrar. Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or~~ inquiry) thereon and from the evidence obtained by said ~~coroner, or~~ inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

a few hours
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by Automobile

a few hours
(Duration) yrs. mos.

(Signed) H K Jonnal, M. D.
(Coroner.)

10-15 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mehren Rosedale — DATE OF BURIAL, 10/16, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Annie Gumenick

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57758

CERTIFICATE OF DEATH.

109

REGISTERED NO. C.....

D 57758

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mehren Hosp. ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Gumenick

(Residence in Baltimore: No. 1418 E Fayette St St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) — (Day), 1873 (Year)

7-AGE. 48 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 03

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15- Filed OCT 16 1921, 191.... ROBERT J. BRAUER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 14 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 13 1921, to October 14 1921, that I saw her alive on October 14 1921, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure.

(Duration) ..... yrs. ..... mos. ½ ds.

CONTRIBUTORY (Secondary) Strangulated Umbilical Hernia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Louis Sachs M. D.

Oct 14, 1921, (Address) The Mehren Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ½ ds. In the State 17 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1418 E Fayette St

19-PLACE OF BURIAL OR REMOVAL, Mehren Rosedale

DATE OF BURIAL, 10/16....., 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57759

CERTIFICATE OF DEATH.

66

D 57759

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5315 Ethelbert Ave ST.; 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Schatz

(a) RESIDENCE. No. 5315 Ethelbert Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dorothea Schatz

6 DATE OF BIRTH (month, day, and year): Sept 10 - 1839

7 AGE: Years 82; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rope Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Minnie Groves

(Address): 5315 Ethelbert Ave.

OCT 16 1921

ROBERT J. BRUTER

Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 14 21

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1921, to Oct 14, 1921, that I last saw h[illegible] alive on Oct 14, 1921, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Senile Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? [illegible] Date of

Was there an autopsy? [illegible]

What test confirmed diagnosis? none

(Signed) W. D. Wells, M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Oct 18th 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E. Nash.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57760

CERTIFICATE OF DEATH.

H 3

D 57760

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Agnes Hosp. ST.: 6 WARD)

2-FULL NAME Mrs Elizabeth Goldberg-

(a) RESIDENCE. NO. 217 N. Pattison Park Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, (Married) Widowed, or Divorced (write the word)
F.	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jack Goldberg.

6 DATE OF BIRTH (month, day, and year) 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55-	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Goldberg (Address) 217 N. Pattison Park Ave

15 Filed OCT 21 1921 19... ROBERT R KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/21 19

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to Oct. 14, 1921, that I last saw her alive on Oct. 14, 1921, and that death occurred, on the date stated above, at 9.50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with General metastasis - Carcinomatosis -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? Yes Date of 7/6/1921

Was there an autopsy? No

What test confirmed diagnosis? Operation + Microscopic Ex.

(Signed) W. E. Caldwell M. D.

10/14 1921 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew M Carmel — DATE OF BURIAL Oct 16 1921

20 UNDERTAKER Max Levinson — ADDRESS 1212 Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57761

CERTIFICATE OF DEATH.

120 D 57761

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Glover ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman C. Makoski

(Residence in Baltimore: No. 822 N. Glover St. St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Married

6-DATE OF BIRTH, Aug (Month) 31 (Day), 1866 (Year)

7-AGE, 55 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Collector 077
(b) General nature of industry, business, or establishment in which employed (or employer) Grocer Collector

9-BIRTHPLACE, (State or Country), Bat Russia

PARENTS.

10-NAME OF FATHER, August Makoski

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Makoski

(Address) 822 N. Glover St

15-OCT 16 1921 ROBERT J. BRISTOW

Filed....., 191.....

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1921, to Oct 14 1921, that I saw h[illegible] alive on Oct 14th 1921, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. ....mos. ....ds.

(Signed) Laws Virgil M. D.

10-17-, 1921 (Address) 2461 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Oct 17th, 1921

20-UNDERTAKER Fredk Lassahn & Sons

ADDRESS Fullerton Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57762

CERTIFICATE OF DEATH.

167 D 57762

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3641 Cedar Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Golden B. Zeke

(Residence in Baltimore: No. 3641 Cedar Ave St. 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 2, 1918
(Month) (Day) (Year)

7-AGE, 2 yrs. 11 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, James A. Zeke

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co

12-MAIDEN NAME OF MOTHER Fannie Sullivan

13-BIRTHPLACE OF MOTHER (State or Country), Montgomery Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. James A. Zeke

(Address) 3641 Cedar Ave

15 OCT 16 1921 ROBERT J. KRAUTER Registrar.

Filed ....., 191.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1921, to Oct 16 1921, that I saw h[illegible] alive on Oct 15 1921, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Burns (Scalded) of chest and arms

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion (summer fatal)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. B. Norment M. D.

10.16.21 1921. (Address) 3642 Chesterwood Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, Oct. 17, 191..

20-UNDERTAKER A. S. Marshall ADDRESS 3390 Reisterstown Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 57763

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 307 Pinnacle Ave. ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Arnold

(a) RESIDENCE. No. 307 Pinnacle Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Arnold

6 DATE OF BIRTH (month, day, and year) June 18 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) dinner

(c) Name of employer L. A. Polemon & Son

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER John Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Schrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas. Arnold.
(Address) 307 Pinnacle Ave.

15 Filed OCT 18 1921 ROBERT J. BRAGUE Registrar
Burial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Oct 15, 1921, that I last saw him alive on Oct 15, 1921, and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) G. H. Buckley, M. D.

(Address) 126 W. Biddle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem.	Oct. 17, 1921
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57764

CERTIFICATE OF DEATH.

17 D 57764

REGISTERED No. C

1-PLACE OF DEATH Ben Ribbon Candy Co' (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 671 W Pratt St ST.: W WARD)

2-FULL NAME Joseph A. Kurrmurt-

(Residence in Baltimore: No. 2550 Frederick av St.: 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec (Month) 4 (Day), 1860 (Year)

7-AGE, 60 yrs. 3 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Candy Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country): Balto md

PARENTS.

10-NAME OF FATHER, Michael Kurrmurt-

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Fehler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. E. Kurrmurt

(Address) 2550 Frederick

15- FILED OCT 16 1921 BOBERT J. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull & Broken Neck

(Duration) a few seconds

CONTRIBUTORY (Secondary) Freldom Elevator Shaft- a few seconds

(Duration) yrs. mos. ds.

(Signed) W K Forrest M. D.
(Coroner)

10-16, 1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Catholic

DATE OF BURIAL, Oct. 17 1921

20-UNDERTAKER Geo. A. Schwab

ADDRESS 2101 Eutaw Pl.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Seba E. Cullom. ✓

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57765 D 57765

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2703 Frederick Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Seba Elizabeth Cullom

(a) RESIDENCE. No. 2703 Frederick Ave ST. 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luke A. Cullom

6 DATE OF BIRTH (month, day, and year) Dec 12, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn. Ford Co. Ill.

PARENTS

10 NAME OF FATHER Wm. Elliott

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania (State or country)

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country)

14 Informant (Address) Chas. A. Cullom 2703 Frederick Ave

15 OCT 16 1921 ROBERT J. BRAUER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1921 to Oct 13 1921

that I last saw h.. alive on Oct 14 1921

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

1 (duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) One yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Rogard M. D.

1921 (Address) 2105 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 18 1921
UNDERTAKER	ADDRESS
George L. Lombard	2108 Eutaw Pl.

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57766

D 57766

CERTIFICATE OF DEATH.

127

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S. Fulton Ave ST. 19 WARD)

2-FULL NAME John Lingrood Mason

(a) RESIDENCE. NO. 226 S. Fulton Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht.

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	XX	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Geo. W. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Pauline A. Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Geo. W. Mason

(Address) 226 S. Fulton Ave

15 OCT 16 1921

BOARD OF HEALTH

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct-12, 1921, to Oct-15, 1921, that I last saw h[illegible] alive on Oct-15, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Circumcision

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James H. Hagerty, M. D.

10/15, 1921 (Address) 1729 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Oct 17 1921

20 UNDERTAKER: Geo. L. Schwab

ADDRESS: 2101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57767 — 43 — D 57767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2329 Madison Ave. | 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia a Marcus.

(a) RESIDENCE. No 2329 Madison Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ottmar Marcus

6 DATE OF BIRTH (month, day, and year) Dec 26 / 186[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Aaron Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Haas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E Marcus (Address) 2329 Madison

15 OCT 16 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Oct. 15, 1921, that I last saw h[illegible] alive on Oct. 15, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Metastases of Carcinoma to skull from Carcinoma of Breast (left) done 10 yrs ago

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Intra cerebral pressure

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? x Ray.

(Signed) Sriam Orld M. D.

. 19 (Address) Alhambra apts B-1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Oct 18 — 1921

20 UNDERTAKER Carl H Sondheim ADDRESS 1818 Mt Royal Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57768 41 D 57768

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital & Old Age Home ST.; ..... WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Rosenfeld

(Residence in Baltimore: No. Hebrew Hospital & Aged Home St.; 60 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, ~~Male~~ Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.) widowed

6-DATE OF BIRTH, Germany June 1848
(Month) (Day) (Year)

7-AGE, 73 yrs. 4 mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Moses Kerngood

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Freda Oppenheim

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Kerngood

(Address) Esplanade Apts

15 OCT 16 1921 ROBERT J KRAUTER
Filed ..... 191 ..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 10 1921, to October 21 1921, that I saw h er alive on October 21 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Moses Jaulson M. D.

10/15, 1921. (Address) Hebrew Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. — mos. — ds. In the State 60 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Hebrew Hosp. & Old Aged Home

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cem. DATE OF BURIAL, 10/16, 1921.

20-UNDERTAKER David Goodheim ADDRESS 1188 W Mt Royal ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57769

CERTIFICATE OF DEATH.

182 D 57769

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1726 Mc Culloh St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Smith

(Residence in Baltimore: No. 1726 Mc Culloh St. St.: (30) yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, November, 29, 1890
(Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Nathaniel Smith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Benjamin Warner

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Rasin

(Address) 2118 Mc Culloh St

15 OCT 16 1921 Filed ..... 191.. ROBERT F. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver shot wound, Head

Instantaneous death

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Homicide

(Duration) yrs. mos. ds.

(Signed) J. T. Hammond (Coroner.) M. D.

Oct. 15, 1921 (Address) 2302 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel County

DATE OF BURIAL, Oct. 17, 1921

20-UNDERTAKER George P. Ralston

ADDRESS 513 Fauquier St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57770

CERTIFICATE OF DEATH.

15 19 D 57770

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 W. Northern ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm W. Hawkins

(a) RESIDENCE NO. 2026 W. Northern ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie L. Hawkins

6 DATE OF BIRTH (month, day, and year) Jan 1, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commis. Mer.

(b) General nature of industry, business, or establishment in which employed (or employer) Gent's

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wallace W. Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Harmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W. Lee Hawkins

(Address) 2026 W. Northern Ave

15 OCT 16 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28 , 1921 , to Oct. 14 , 1921 , that I last saw h[illegible] alive on Oct. 14 , 1921 , and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Emphysema (History 6 months)

Bronchitis about 40 yrs

(duration) 10 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy, arterio Sclerosis.

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Howard Bruner, M. D.

, 19 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 19 21
20 UNDERTAKER	ADDRESS
W. H. McKnew & Son	North Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57771 ✓ D 57771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 219 So High ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mantone

(a) RESIDENCE. No. 219 So High ST., 3 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 1/2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) October 15-1921

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Anthony Mantone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Frances Ricci 10/16. 1924

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Anthony Mantone (Address) 219 So High St

15 OCT 16 1921 ROBERT A. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15 1921

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1921, to October 15, 1921, that I last saw him alive on October 15, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Failure of closing Foramen Ovale (Blue Baby) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Failure (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Joseph L. Valentine, M. D.

(Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	October 17 1921
20 UNDERTAKER	ADDRESS
Kendall & Heppe Inc	27 E Lanvale

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57772

CERTIFICATE OF DEATH.

9 D 57772

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Glenwood Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Inez Genevieve Butts.

(Residence in Baltimore: No. 717 Glenwood Ave St.; 6 yrs., 5 mos. 28 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, ~~Oct~~ April 17th, 1915 (Month) (Day) (Year)

7-AGE, 6 yrs. 5 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, William T. Butts

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Ida Butler Small

13-BIRTHPLACE OF MOTHER (State or Country), Talbot Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Butts

(Address) 717 Glenwood Ave.

15- Filed OCT 16 1921 ROBERT J. KRAUTER Registrar

Burial ... Record ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1921, to Oct 15 1921, that I saw her alive on Oct 15 1921, and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

Sudden failure of heart action (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos. 4 ds.

(Signed) E. H. Duncan M. D.

Oct 15, 1921. (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 10/16, 1921

20-UNDERTAKER Henry W. Meas & Son

ADDRESS 805 N. Calvert St

57773 HEALTH DEPARTMENT—CITY OF BALTIMORE 57773

D 57773 CERTIFICATE OF DEATH. 17 D 57773

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE (No. 2613 Frances St. 13 WARD)

2-FULL NAME Margaret A Murphy

(Residence in Baltimore: No. 2613 Frances St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

25

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1873
(Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Murphy

(Address) 2613 Frances St

15-

Filed OCT 3 1921, 191.....

[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, OCT 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows: Injuries received from falling from Step Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Kennedy M. D.
(Coroner)

OCT 16, 1921. (Address) 532 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State 25 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Oct 17, 1921

20-UNDERTAKER Maurice Fahey & Son — ADDRESS 827 W Monty

Spec.—6-9-19—H. P. Co.—1000 Blks.

57774
D 57774

HEALTH DEPARTMENT—CITY OF BALTIMORE

57774
D 57774

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1325 S. Bowlden ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby Zita Ford

(a) RESIDENCE. No. 1325 S. Bowlden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 10-10-1914

7 AGE: Years 6 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William A. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Doris H. Kratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Doris H. Ford
(Address) 1325 S. Bowlden

15 Filed OCT 17 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/16/1921

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1921, to 10/16, 1921, that I last saw h[illegible] alive on 10/16, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

1 Premature Expulsion
2 Foetus Ascites Fluid Abdomen

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 1 Premature Expulsion
2 Foetus Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Fuller, M. D.

10/16 1921 (Address) 3313 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulaney Valley Mem. Park	Oct. 17th 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H.C.P. Co.—1000 Bks.

15 1235 57775 57775 57775

HEALTH DEPARTMENT—CITY OF BALTIMORE CERTIFICATE OF DEATH.

X 150 ✓ 57775 D 57775

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward O. Pitcher

(a) RESIDENCE. No. Bethlehem, Pa ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 18th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 880

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala

PARENTS

10 NAME OF FATHER Edward

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant JOHNS HOPKINS HOSPITAL. Records
(Address)

15 Filed OCT 17 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-10 . 1921 . to 10-16 . 1921 .

that I last saw h[illegible] alive on 10-16 . 1921 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

hydrocephalus

(duration) 2 yrs. 8 mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Alabama.

Did an operation precede death? yes Date of Oct 10, 1921

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J. L. Houghton, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newark N. J.	10/18/21 19
20 UNDERTAKER	ADDRESS
H. E. Myles	Peter W. Body

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57776 150849 D 57776 CERTIFICATE OF DEATH. X 50 D 57776

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) (Ward) 7

2-FULL NAME Mrs Martha A. Sharpless

(a) RESIDENCE. No. Ebensburg (St.) Pa. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? 59 yrs. 8 mos. 29 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Charles Sharpless

6 DATE OF BIRTH (month, day, and year) Jan 18, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Andrew Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Martha Dale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: JOHNS HOPKINS HOSPITAL. Records

(Address)

15 [illegible] 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 16, 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1921. to Oct. 16, 1921.

that I last saw h[illegible] alive on Oct. 16, 1921.

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

B. Coli Septicaemia - Bilateral Pyelonephritis. - Myocarditis - Bronchopneumonia

(duration) Pyelonephritis 6 mos. Septicaemia 4 days

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ebensburg, Pa.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture urine culture Blood sugar

(Signed) J. R. Johnson M. D.

. 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebensburg Pa.	10/16/21 19
20 UNDERTAKER: M. E. Hughes	ADDRESS: 424 S. Broadway

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57777

CERTIFICATE OF DEATH.

170

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Harford Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace E. Mitchell

(a) RESIDENCE. No. 1814 Harford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15. yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-30-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Kansas. State. md.

PARENTS

10 NAME OF FATHER: John Steiner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kansas State ~~ohio~~.

12 MAIDEN NAME OF MOTHER: Grace Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kansas. md.

14 Informant: George B. Mitchell
(Address) 1814 Harford ave

15 Filed OCT 17 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Oct 13, 1921, that I last saw her alive on Oct 13, 1921, and that death occurred, on the date stated above, at 3304 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secandary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical-urinary

(Signed) J. H. Hornbeim, M. D.

10/14, 19-1 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct. 17 1921
20 UNDERTAKER	ADDRESS
George F. Rutter	1735. Harford ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57778

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 521 S. Regester ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew J. Backert.

(Residence in Baltimore: No. 521 S. Regester. St.: yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH. Oct. 5 *, 1875
(Month) (Day) (Year)

7-AGE. 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt md

PARENTS.

10-NAME OF FATHER, John Backert.

11-BIRTHPLACE OF FATHER (State or Country), Balt. md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Balt. md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Caroline Backert.

(Address) 521 S. Regester.

15-

ROBERT B. KRAUTER

Filed OCT 7 1921, 191.... Social Service Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Henry Lyon Forsyth, M. D.
(Coroner.)

Oct 16 1921, (Address) 1600 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery

DATE OF BURIAL, Oct. 17, 1921

20-UNDERTAKER George J. Rutter

ADDRESS 1735 Hayford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57779 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 57779

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 S Ann ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Szymski

(a) RESIDENCE NO. 518 S Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lorence Szymski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Walerya Kozlawski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Walerya Szymski

(Address) 518 S Ann St

15 Filed OCT 1 1921 19 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1921 to Oct. 15 1921,

that I last saw him alive on Oct. 15 1921,

and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) — yrs. mos 12 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John H. Kelberger M. D.

19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 17 1921

20 UNDERTAKER John M Weber 1303 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 D 57780

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) 4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Postley

(a) RESIDENCE. No. 604 N. Saratoga St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 23, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Thomas Postley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Preler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Addie Postley
(Address) 604 N. Saratoga St

15 Filed ..., 19... DOTEY I. ISAACS Registrar

OCT 17 1921 Death Certificate Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1921, to Oct 16, 1921, that I last saw him alive on Oct 16, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

(1) Tuberculer meningitis

Autopsy also showed miliary tuberculosis

(duration) ... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Path. Exam. Tuberculosis

(Signed) John J Edwin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Martins Md	Oct 18 1921
20 UNDERTAKER Tradwin	ADDRESS 142
John W. Tradwin	W Fitch St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57781

CERTIFICATE OF DEATH.

150

D 57781

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bessmer ave Grasslands) Ward 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franke B Warnick

(a) RESIDENCE. No. Bessmer ave Grassland Park ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Wesley Warnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Cathrin M Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Wesley Warnick
(Address) Bessmer ave

15 Filed OCT 17 1921 BOLEY J. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Oct 15, 1921, that I last saw him alive on Oct 15, 1921, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Non-Closure Foramen Ovale

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr John G. Owens, M. D.

Oct 16 1921 (Address) 38 n Potomac st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenly	Oct 17 1921

20 UNDERTAKER Wendell Wippel & Son ADDRESS 378 n

FOR IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-091 ✓

D 57782

CERTIFICATE OF DEATH.

D 57782

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 E Randall St.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Vogelsang.

(a) RESIDENCE. No. 18 E Randall. St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Vogelsang.

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Vogelsang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary C Vogelsang

(Address) 18 E Randall St

15 Filed OCT 17 1921 BOYER & CLARKE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1921, to Oct 15, 1921, that I last saw h[illegible] alive on Oct 15, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lea Grippe

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

Oct 18 1924 (Address) 1204 Hillman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	10/17 1921
20 UNDERTAKER	ADDRESS
E B. Harle	1152 West St

Spec.—8-24-14—M. & T.—2000 Blks.

D 57783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57783

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Foerster Ave. Lakeland ST.; 25th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Susan Jane Stapf.

(Residence in Baltimore: No. Foerster Ave. Lakeland St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, January (Month) 4 (Day), 1851 (Year)

7-AGE, 40 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pennsylvania.

PARENTS.

10-NAME OF FATHER, Robert Hanna

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Jane Hanna Davis

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward F. Stapf

(Address) Foerster Ave. Lakeland

15- ROBERT J. KRAUTER Registrar.

FILED OCT 17 1921 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 16 (Day); 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Oct 16 1921, that I saw h.. alive on Oct 16 1921, and that death occurred, on the date stated above, at 1.16 p.m.

The CAUSE OF DEATH* was as follows:
acute dilatation of the heart.
(Duration) ..... yrs. 18 hrs mos. .....

CONTRIBUTORY (Secondary) Mitral Regurgitation
(Duration) ? yrs. ..... mos. ..... ds.

(Signed) H. Lawrence Wheeler, M. D.
Oct. 16, 1921. (Address) Lakeland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Oct 18 1921

20-UNDERTAKER Jos Foersdens Son ADDRESS 217 S. Pac.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57784

CERTIFICATE OF DEATH.

79 ~ D 57784

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3436 Belair Rd ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Sullivan

(Residence in Baltimore: No. 3436 Belair Rd. St. 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	widowed

6-DATE OF BIRTH, Aug 30, 1833
(Month) (Day) (Year)

7-AGE, 88 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Enos Wells

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan ——

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Raden

(Address) 3436 Belair Rd

15- Robert F. KRAUTER

Filed OCT 17 1921 for Burial Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 1921, to Oct 1921, that I saw her alive on Oct. 7 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

..Myocarditis.....

..... (Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) yrs. mos. ds.

(Signed) Jacob Frahm M. D.

Oct 15, 1921 (Address) 1823 N. Wash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Parkwood Cemetery	Oct 17, 1921

20-UNDERTAKER E. LeRoy Steffler ADDRESS 125 E. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57785

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 W North Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Bachmann

(a) RESIDENCE. No. 2433 W. North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Bachmann

6 DATE OF BIRTH (month, day, and year) Nov 11 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Merth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Bachmann

(Address) 2433 W North Ave

15 Filed OCT 17 1921, 19 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6- 1921, to Oct 14, 1921.

that I last saw her alive on Oct 14, 1921.

and that death occurred, on the date stated above, at 12,30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E Kelly Hemming, M. D.

10/16, 1921 (Address) 7000 Holland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 17 1921

20 UNDERTAKER Harry H. Witzke

ADDRESS 1531 W Lanvale

Spec.—5-19-13—M. & T.—500 Bks.

Wessel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57786 | 108 ✓ | D 57786

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Mosher St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C Wessell

(Residence in Baltimore: No. 1717 Mosher 66 Yrs)

St.; 91 yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, November 3, 1829 (Month) (Day) (Year)

7-AGE, 91 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Gardner
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, — Wessel

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Lewis

(Address) 1717 Mosher St

15- FILED OCT 17 1927 ROBERT J KRAUTER Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 15 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1927, to Oct 15 1927, that I saw him alive on Oct 14 1927, and that death occurred, on the date stated above, at 8:30a m.

The CAUSE OF DEATH was as follows:*

Cerebral Hemorrhage

(Duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Dementia

(Duration) yrs. 1 mos. 7 ds.

(Signed) Irvin Ebaugh M. D.

Oct. 15, 1927 (Address) 710 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct. 18, 1927

20-UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 57787

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No Brem & Lombard ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Roach

(a) RESIDENCE. NO. 649 Lee St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Roach

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Lillian Parrott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) University Hosp. Records.

15 Filed OCT 17 1921 ROBERT P. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Oct 15, 1921, that I last saw h[illegible] alive on Oct. 15, 1921, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows: Tuberculous Peritonitis

(duration) ? yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Oct. 3, 1921

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. B. Wells, M. D.

. 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Oct 17 1921
20 UNDERTAKER	ADDRESS
R. L. Parham	649 N. Lee

Spec.—1-10-21—M&T—1500 Blks.

D 57788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57788

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Pa. Ave. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Conyer

(a) RESIDENCE NO. 1412 Pa. Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11 /21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER James Conyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Conyer

(Address) 1412 Pennsylvania Ave

Filed OCT 17 1921 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1921, to Oct 15, 1921, that I last saw him alive on Oct 14, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

(Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Oct 19 1921

20 UNDERTAKER Edward Ruggold — ADDRESS 1463 Carey

D 57789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D 57789

REGISTERED No. C

1 PLACE OF DEATH Office of William Wilkens & Co

CITY OF BALTIMORE (No. Frederick ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

John Henry

2 FULL NAME Gustav Siegmund

(Residence in Baltimore: No. 1918 Wilkens ave St.: yrs., mos. ds.)

55

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 21st (Day), 1846 (Year)

7-AGE, 75 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Agent 086
(b) General nature of industry, business, or establishment in which employed (or employer) Wm Wilkens & Co

9-BIRTHPLACE, (State or Country), Hamburg, Germany

PARENTS.

10-NAME OF FATHER Christian Siegmund

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Sophie Wiecke

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Siegmund

(Address) 1825 W. Lexington St.

15- Filed OCT 17 1921, 191.. ROBERT E KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Ruptured Coronary artery Sudden

(Duration) yrs. mos. ds.

(Signed) James M Denbow M. D. (Coroner.)

Oct 14 1921. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, Oct 17, 1921

20-UNDERTAKER Joseph B Cook — ADDRESS 1003 W. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57790

CERTIFICATE OF DEATH.

167 D 57790

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1121 Hanlick St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Carson

(Residence in Baltimore: No. 1121 Hanlick St.)

38 9 14
St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	single

6-DATE OF BIRTH, Jan (Month) 1 (Day), 1883 (Year)

7-AGE, 38 yrs. 9 mos. 14 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer): Bartlett Hayward

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Geo. M. Carson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Sarah M Henry

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie H Thomas

(Address) 1121 Hanlick St

15-

FILED OCT 17 1921 19.. BOWEN S. KRAUTER Registrar.

Burial Permit 0553

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

30 Minutes Cerebral Hemorrhage
Fracture of Skull accident while
Employed Bartlett Hayward Co which at work

(Duration) ....yrs. ....mos. 14 da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....da.

(Signed) James M Fenton M. D.
(Coroner.)

Oct 14 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Wilmark Cem. Elkridge Md	Oct 17, 1921
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Balto St

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57791

CERTIFICATE OF DEATH.

28 D 57791

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore F. Wharton

(a) RESIDENCE. No. 1718 Barclay st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Wharton

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Gordon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address) M. T. H.

15 Filed OCT 17 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to Oct. 16, 1921, that I last saw him alive on Oct. 15, 1921, and that death occurred, on the date stated above, at 12.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum. X-ray

(Signed) Francis L. Dadayliaen M. D.

10-16-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 18 1921
20 UNDERTAKER Roth Funeral Co.	ADDRESS 1 & Fr. N. Bway.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57792

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1952 Greenmount ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sheehan

(a) RESIDENCE. NO. 1952 Greenmount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Cornelius Sheehan. Dec 6 1835

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER James O'hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Sheehan

(Address) 1953 Greenmount Ave

15 Filed OCT 17 1921 ROBERT J. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th, 1921, to Oct 16th, 1921.

that I last saw her alive on Oct 16th, 1921.

and that death occurred, on the date stated above, at 5 10/a m.

The CAUSE OF DEATH* was as follows:

Senile Degeneration.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Cunningham M D, M. D.

10/16 1921 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Oct 14 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E Nath

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57793

CERTIFICATE OF DEATH.

144 D 57793

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Lathe

(a) RESIDENCE. No. Warner St-Mt Winans WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	white	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Carrie Lathe

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper in Cold Storage Plant

(b) General nature of industry, business, or establishment in which employed (or employer) Wilson & Martin abbatoir

(c) Name of employer Harvey Cooper

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thos. P. Lathe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Sarah Zepp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Carrie Lathe (wife)

(Address) Warner St-Mt Winans

15 FILED OCT 17 1921 [redacted] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-5-, 1921, to 10-16-, 1921, that I last saw him alive on 10-16-, 1921, and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mediastinal abscess (ruptured) (duration) yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Strict partial

What test confirmed diagnosis? Microscopical & Bacter'l

(Signed) H. V. Harper M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 20 1921
20 UNDERTAKER	ADDRESS
William Cooke	502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57794 — 1-PLACE OF DEATH

79 D 57794 — REGISTERED NO.

CITY OF BALTIMORE (No. 2414 Auraah Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Salgee

(a) RESIDENCE. No. 2414 Auraah Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Oliver Salgee

6 DATE OF BIRTH (month, day, and year): Oct 3 - 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Ida F. Stone
(Address) 2414 Auraah Ave

15 Filed ... 19 ... ROBERT J. KRAUTER Registrar
OCT 17 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Oct 15, 1921,
that I last saw h alive on Oct 15, 1921,
and that death occurred, on the date stated above, at 330 P m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter Horn M. D.

10/19 1921 (Address) 3505 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 18 1921
20 UNDERTAKER: William Cook	ADDRESS: 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57795

CERTIFICATE OF DEATH.

67 D 57795

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 21 N Poppleton ST., 18 WARD)

2-FULL NAME Theresa Iglehart

(a) RESIDENCE NO. 21 N Poppleton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J Iglehart

6 DATE OF BIRTH (month, day, and year) Sept 21 1850

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Eindmuth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eindmuth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William J Iglehart
(Address) 21 N Poppleton St

15 Filed OCT 17 1921 ROBERT J KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1921, to Oct 16, 1921, that I last saw h... alive on Oct 15, 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Oct 17/21 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Oct 1921

20 UNDERTAKER: W E Oak 5026 E North Ave ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

57796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57796

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Walbrook Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Elizabeth White

(a) RESIDENCE. NO. 3210 Walbrook Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If of foreign birth? 79 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert White

6 DATE OF BIRTH (month, day, and year) Aug 30, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Antrim County Ireland

PARENTS

10 NAME OF FATHER John McCahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah Getty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Robert White

(Address) 3210 Walbrook ave

15 OCT 17 1921

ROBERT S. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from 1.30 Pm Oct 15th 1921, to 4.30 Pm Oct 15th 1921, that I last saw her alive on Oct 15th 1921, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 5 hours mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo H Cairns, M. D.

, 19 (Address) 21 W 24th St Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 18 1921
20 UNDERTAKER	ADDRESS
Chas. E. Black	742 W. North Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57797

14957797

CERTIFICATE OF DEATH.

REGISTERED NO. 54

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Lautzbager

(a) RESIDENCE. NO. 1036 N. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-29-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Michael Lautzbergen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jeanette Kurtzberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed OCT 17 1921 ROBERT J. KRAUSE Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-4, 1921, to 10-15, 1921, that I last saw him alive on 10-15, 1921, and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pernicious anaemia; pyelonephritis?

(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) John L. Jungerg, M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: Oct 18 1921

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Madison

Spec.—1-10-21—M&T—1500 Bks.

D 57798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57798

CERTIFICATE OF DEATH.

15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3516 E. Pkla. ave ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter G. Carnohan

(a) RESIDENCE NO. 3516 E. Pkla. ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) July 29-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Joseph Carnohan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Eliza Hyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant Joseph Carnohan

(Address) 3516 E. Pkla ave

15 OCT 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1921 to Oct. 15 1921,

that I last saw him alive on Oct 15, 1921,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth:

not developed

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Imley. M. D.

, 19 (Address) 2858 E. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Funk Cem	10-17 1921
20 UNDERTAKER J. A. Moran	ADDRESS 1700 E Balto

TION is very important. See instructions

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57799

CERTIFICATE OF DEATH.

ng D 57799

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 566 Biddle Alley St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Freeman

(Residence in Baltimore: No. 566 Biddle alley

~~St.~~ 20 ~~yrs.,~~ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... January ....., 1885
(Month) (Day) (Year)

7-AGE, 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... General Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... N.H.D.

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Frank Freeman

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Eden Harris

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Freeman

(Address) 412 Pearl St.

15-

Filed OCT 17 1921 191.. ROBERT F. KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy (Coroner.) M. D.

Oct. 18, 1921 (Address) 802 Fairmount Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Oct 17, 1921

20-UNDERTAKER David J. Hennessy ADDRESS 702 N. Bedford St.

Spec.—1-10-21—M&T—1500 Bks.

D 57800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 57800

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3330 Hudson ST., 26 WARD)

2-FULL NAME Amelia Frances Romean

(a) RESIDENCE No. 3330 Hudson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Casper Romean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Catherine Reuter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co.

14 Informant Casper Romean
(Address) 33 N. Hudson St.

15 Filed OCT 17 1921 ROBERT I. KRAUTER Registrar

TION is very important. See instruction on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1921, to Oct. 17, 1921, that I last saw h[illegible] alive on Oct. 12, 1921, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition.

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Athey, M. D.

10/16, 1921 (Address) 2004 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Oct 17 1921
20 UNDERTAKER Lilly and Zeiler.	ADDRESS [illegible]

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of having Had gastro enteritis before Dr Athey attended Poorly nourished from birth.

Spec.—1-10-21—M&T—1500 Bks.

D 57801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S. East Ave. St., 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Schemann.

(a) RESIDENCE No. 406 S. East Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Compositor 063

(b) General nature of industry, business, or establishment in which employed (or employer) Theo Print. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Schemann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Veronica Wellshofer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Veronica Schemann.
(Address) 406 S. East Ave.

15 Filed OCT 17 1921 ROBERT J. KRAUTER Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from 9 Oct, 1921, to 15 Oct, 1921, that I last saw him alive on 15 Oct, 1921, and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) Streptococcus + Staphylococcus infection of throat (duration) yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? On Throat Date of 10 Oct

Was there an autopsy? No

What test confirmed diagnosis? Culture + slides

19/14/1921 (Signed) Ostmoler, M. D.

(Address) 301 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct 18 1921
20 UNDERTAKER Lilly and Feiler	ADDRESS 403 S Monroe

TION IS very important. Be sure to answer

D 57802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 57802

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1933 Biddle ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Cassell.

(Residence in Baltimore: No. 1933 E. Biddle St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Bach

6-DATE OF BIRTH: ....., 1 ..... (Month) (Day) (Year)

7-AGE: ..... yrs. 4 mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None 000

9-BIRTHPLACE (State or Country): born in Baltimore

PARENTS.

10-NAME OF FATHER: Dennis Cassell

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Annie Cassell

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Washington

(Address) 1933. E Biddle

15-

Filed ..... 191.....

ROBERT J. KRAUTER

OCT 17 1921 Burial ... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

....., 191.., (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	Oct-17, 1921
20-UNDERTAKER Mrs R A Elliott	ADDRESS 1725- Oakland Ave

Important. See instructions on back of certificate.

Spmc.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57803

CERTIFICATE OF DEATH.

92 D 57803

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1238 Orleans ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Denison Cooper

(a) RESIDENCE. No. 1238 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country) born in Balt—

PARENTS

10 NAME OF FATHER Denison Cooper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Emma Mapp

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Emma Cooper
(Address) 1238 Orleans

15 Filed ..... 19.. ROBERT J. KRUT Registrar

OCT 17 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1924, to Oct 15, 1924, that I last saw h alive on Oct 14, 1924, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher M. D.

10-17-24 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Oct 17 1924

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57804

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 091 D 57804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital, Baltimore. REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST.: 12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Vickers White

(a) RESIDENCE. No. 2913 Guilford Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White American	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Patton White

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deputy Internal Revenue collector 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown Md.

PARENTS

10 NAME OF FATHER John H. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury Md.

12 MAIDEN NAME OF MOTHER Annette J. Vickers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestertown Md.

14 Informant Wm. J. Gordy Jr. (Address) Salisbury Md.

15 Filed . 19 Registrar

OCT 17 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8th, 1921, to Oct. 17th, 1921, that I last saw him alive on Oct. 17th, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Hypertensive cardio renal syndrome c the nephropathy predominating in the picture, the final stage showing uremia

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(durotion) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumin ++, Casts in fine granular urine

(Signed) George E. Hardy, M. D.

19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salisbury Md DATE OF BURIAL: April 19 1921

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 E. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 57805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57805

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4819 Park Heights Ave St.; 47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Haviland Price

(Residence in Baltimore: No. 4819 Park Heights Ave St.: 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: W.

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED.~~ (*Write* the word.): Married

6-DATE OF BIRTH: April 19, 1855 (Month) (Day) (Year)

7-AGE: 66 yrs. 5 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Griffith & Turner Co.

9-BIRTHPLACE, (State or Country): Hartford Co. Md

PARENTS.

10-NAME OF FATHER: Edward C. Price

11-BIRTHPLACE OF FATHER (State or Country): Balto. Co. Md.

12-MAIDEN NAME OF MOTHER: Caroline Haviland

13-BIRTHPLACE OF MOTHER (State or Country): New York State

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mrs. Lucy C. Price

(Address): 4819 Park Heights Ave

15-

Filed OCT 17 1921 E Wolman Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1921, to Oct 15th, 1921, that I saw him alive on Oct 15th, 1921, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation accompanied by mitral valve insufficiency of indefinite duration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute bronchitis

Patient about 10 days (Duration) yrs. mos. ds.

(Signed) Edwards C. Price M. D.

, 191... (Address) 1.0.1. Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Oct. 18, 1921

20-UNDERTAKER: Geo. J. Smith — ADDRESS: 1900 Gaye St

D 57806 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 D 57806

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3000 Clifton Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME W. Morse Keener

(Residence in Baltimore: No. 3000 Clifton Ave Sto 52 ~~Life~~ yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 ~~SINGLE~~ MARRIED ~~WIDOWED OR DIVORCED~~ (Write the word) Married

6 DATE OF BIRTH May 2, 1869 (Month) (Day) (Year)

7 AGE 52 yrs. 5 mos. 14 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Proof reader for the Baltimore News
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Washington D C

PARENTS

10 NAME OF FATHER John Henry Keener

11 BIRTHPLACE OF FATHER (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Martha Morse

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mable J. Keener

(Address) 3000 Clifton Ave.

15. OCT 17 1921 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 16, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1921, to Oct. 16 1921, that I saw him alive on Oct 16, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Heart Failure
(Myocarditis)

(Duration) 0 yrs. 0 mos. 14 ds

Contributory (SECONDARY) none

(Duration) ... yrs. ... mos. ... ds.

(Signed) S. A. Dodds M. D.

Oct 17, 1921 (Address) 3101 Clifton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park — DATE OF BURIAL Oct. 19, 1921

20 UNDERTAKER George J. Smith — ADDRESS 1800 Fayette St.

is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57807

CERTIFICATE OF DEATH.

1055 D 57807

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST.: 29 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schuster

(a) RESIDENCE. NO. 729 Harvey Stack ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry L. Schuster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. Records
(Address)

15 Filed OCT 17 1921 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1921, to Oct. 17, 1921, that I last saw her alive on Oct 17, 1921, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Epidemic encephalitis.

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? 729 So Harvey St

Did an operation precede death? No Date of

Was there an autopsy? ✓ No

What test confirmed diagnosis? ✓

(Signed) Chas C Mason, M. D.

10/17, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Brooklyn	Oct 20 1921

20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57808

CERTIFICATE OF DEATH.

115 D 57808

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.: 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 3 Mrs. Livinia Penn.

(a) RESIDENCE. No. 3623 Ash Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tom Penn

6 DATE OF BIRTH (month, day, and year) Jan 3 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Viggetta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Livington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John Penn

(Address) 3623 Ash Ave

15 Filed OCT 17 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to 10-15, 1921, that I last saw her alive on 10-15, 1921, and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

General Septicemia

OVER

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-9-21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Caldwell, M. D.

. 19 (Address) St Agnes Hspta

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Oct 18 1921

20 UNDERTAKER: Chenowith Lon Chestnut — ADDRESS

[REVISED UNITED STATES STANDARD]

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for drainage of gall bladder. Gallstones

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57809

CERTIFICATE OF DEATH.

120 D 57809

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 S. East Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Concannon

(a) RESIDENCE. No. 26 S. East Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Concannon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Richard Feeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Concannon

(Address) 26 S. East Ave

15 OCT 17 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1919, to Oct 15, 1921, that I last saw h[illegible] alive on Oct 15, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Chronic Paramethymatous typhlitis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic arteriosclerosis Rheumatism

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) [illegible], M. D.

10/16, 1921 (Address) [illegible] MD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cem.

DATE OF BURIAL 10/19 1921

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 118 W. Mt. Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57810 STATE BIRTH NO. D 57809

CERTIFICATE OF DEATH.

151 REGISTERED NO. C.....

D 57810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2605 Highland Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Frederick Ball Jr.

(Residence in Baltimore: No. 2605 Highland Ave St.; 2 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Wh	

6-DATE OF BIRTH, 10 (Month) 16 (Day) 21 (Year), 1

7-AGE, 6 mo 5 mos. 5 da. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. John Frederick Ball

11-BIRTHPLACE OF FATHER (State or Country). Baltimore City

12-MAIDEN NAME OF MOTHER Whittington

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss E. N. Whittington

(Address) 2605 Highland

15- OCT 17 1921 191..... ROBERT J. KRAUTER Registrar.

Filed ..... 191..... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 16 (Day) 21 (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from 10/16/21 191..., to 10/16/21 191..., that I saw h[illegible] on 10/16/21 191..., and that death occurred, on the date stated above, at 7 1/2 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 hrs

(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) prematurity

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) O. T. Berman M. D.

10-17 1921 (Address) 2919 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Oct 17, 1921.

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Mad St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

) 57811

CERTIFICATE OF DEATH.

#D 57811

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 102 N. Durham ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Britha Stewart

(a) RESIDENCE. No. 102 N. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Stewart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti And

PARENTS

10 NAME OF FATHER Sam'l Band

11 BIRTHPLACE OF FATHER (city or town) (State or country) And

12 MAIDEN NAME OF MOTHER Ella Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) And

14 Informant Grandma Band
(Address) 728 N. Spring St

15 OCT 17 1921

MORRIS A. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1921, to Oct. 15, 1921, that I last saw h[er] alive on Oct. 15, 1921, and that death occurred, on the date stated above, at 11-52 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Dec. 1919

Was there an autopsy? no John Hopkins Hospital

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

10-17-1921 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 19th 1921
20 UNDERTAKER	ADDRESS
Chas E Bailey	647 Gilmor

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57812

D 57812

CERTIFICATE OF DEATH.

REGISTERED NO. 151

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 S. Bouldin (St.) (Ward) 76

2-FULL NAME Emily Adelaide Ford

(a) RESIDENCE. No. 132 S. Bouldin St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 10/10/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER William A Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Doris A Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City Md

14 Informant Doris A. Ford
(Address) 132 S. Bouldin St

15 FILED OCT 17 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16/21

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1921, to 10/16/21, 19 ,
that I last saw h[illegible] alive on 10/16, 1921,
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Primary Infection Tonsils and Ascending Pulm Edema
(duration) 6 7 mos. ds.

CONTRIBUTORY (Secondary) Tonsilitis Primary Endocarditis
(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Sadler, M. D.

10/16, 1921 (Address) 3323 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	Oct 17 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2006 Orleans St

D 57813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 57813

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hospital St., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Henry

(Residence in Baltimore: No. 807 S. Broadway St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, [illegible]-Brown, (Month) 1 (Day) (Year)

7-AGE, 50+ yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pat. E. O'Lilly

(Address) 402 S. Wolfe St.

15-

OCT 17 1921 191 [illegible] Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 15, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) H. Ingalls

(Duration) yrs. mos. ds.

(Signed) M. D.

10-17, 1921. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL Holy Cross Cem't DATE OF BURIAL, Oct 17, 1921

20-UNDERTAKER Lilly & Zeber ADDRESS 403 S. Wolfe St.

Baltimore Road.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57814

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp ST. 18 WARD)

2-FULL NAME Ethel Burke.

(a) RESIDENCE. NO. Nursery & Child Hosp WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General natore of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk.

14 Informant Nursery Childs Hosp
(Address) Mosade

15 Filed OCT 17 1921 ROBERT J. KRAUTZ
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 / 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1921, to 10 / 13, 1921.

that I last saw her alive on 10 / 13, 1921.

and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Central Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Emil P. Zeigler, M. D.

, 19 (Address) 700 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interred

DATE OF BURIAL Oct 18 1921

20 UNDERTAKER Robt Hamme

ADDRESS 1462 Broadway

D 57815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 57815

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1238 Darley ST. 9 WARD)

2-FULL NAME Baby Levin

(Residence in Baltimore: No. 1238 Darley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH, Oct 16, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, 23 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, George Levin

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Frances Hirsch

13-BIRTHPLACE OF MOTHER (State or Country). New York.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Frances Levin

(Address) 1238 Darley Ave

15- OCT 17 1921 Filed ..... 191... ROBERT P. KRAUTH Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A R Jamison M. D.
(Coroner)

Oct 20, 1921. (Address) 7 E Mt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Parkwood Cemetery | DATE OF BURIAL, Oct 19 1921

20-UNDERTAKER Elmer W. Conklin | ADDRESS 324 E Eager

Spec.—1-10-21—M&T—1500 Bks.

D 57816

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 57816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Reynolds ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME STEPHEN LESNEWSKI,

(a) RESIDENCE NO. 1300 Reynolds ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10/21.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md,.

PARENTS

10 NAME OF FATHER John Lesnewski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Anna Budny,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Stephen Budny,

(Address) 1300 [illegible]

15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17" 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6 - 1921, to Oct - 17 - 1921.

that I last saw h~~e~~ alive on Oct 15, 1921,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis —

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) General Weakness

(duration) yrs. ½ mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Dr R C Brunner, M. D.

, 19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, — DATE OF BURIAL Oct 18" 1921.

20 UNDERTAKER M. J. Jadowski, — ADDRESS 1408 S. Ann St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57817

CERTIFICATE OF DEATH.

157 D 57817

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1528 Olive ST.: 23 WARD)

2-FULL NAME. Ella Reinhardt

(a) RESIDENCE. NO. 1528 Olive ST., 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 13 hours yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 13 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wilbur B. Reinhardt

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth V. Weisl

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Wm. B. Reinhardt
(Address) 1528 Olive St.

71921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 to Oct 16, 1921.

that I last saw h[illegible] alive on Oct 16, 1921.

and that death occurred, on the date stated above, at 10:57 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Pallida.

13 hours.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F Buethner M. D.

. 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct. 17 19[illegible]

20 UNDERTAKER
(a) August Ley

ADDRESS
1000 S. Paca

Spec.—1-10-21—M&T—1500 Bks.

A 15728 D 57818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57818

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

2-FULL NAME Corneline de Vries

(a) RESIDENCE NO. 207 S. Callington Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-25-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Pauwel de Vries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Hendrika Vander Bont

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Johns Hopkins Hospital Records
(Address)

15 10/17 1921 Robert P. Harrison, 19 18591 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15 1921

17

I HEREBY CERTIFY, That I attended deceased from 10-12, 1921, to 10-15, 1921, that I last saw him alive on 10-15, 1921, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Broncho.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 207 S. Callington Ave.

Did an operation precede death? ✓ Date of .....

Was there an autopsy? Yes. (State Anatomical).

What test confirmed diagnosis?

(Signed) Clean Olsson, M. D.

10/15, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health. OCT 19 1921

TION is very important. See instructions

Spec. 1-10-21 M&T 1500 Blks.

D 57819 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57819

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 8 WARD)

2-FULL NAME Rosa L'Lardo

(a) RESIDENCE NO. Florence Crittendon Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23rd 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
		1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ? L'Lardo

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Johns Hopkins Hospital
(Address)

15 Filed OCT 17 1921, 19 Robert P. Harrison, Registrar
(1859)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 27th, 1921, to Oct 11, 1921,
that I last saw her alive on Oct 11, 1921,
and that death occurred, on the date stated above, at 1 20 P.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (Not dysentary).

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? ✓ Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? ✓

(Signed) Eleanor Mason M. D.

10/12, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS OCT 15 1921

Spec.—1-10-21—M&T—1500 Blks.

D 57820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57820

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Berry

(a) RESIDENCE NO. 709 N. Arena ST., WARD .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-12-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Louis Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Gladys Nicholson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant ..... (Address) Johns Hopkins Hospital Records

15 Filed OCT 17 1921, 19.... Robert P. Harrison, Registrar

18580

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14 1921

17

I HEREBY CERTIFY, That I attended deceased from 10-12 ....., 1921, to 10-14 1921,

that I last saw her alive on 10-14 1921,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Date of ....

Was there an autopsy? Yes

What test confirmed diagnosis? ....

(Signed) Horace G. Stewart, M. D.

10/19, 1921, (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

OCT 19 1921

Department of Health,

Commissioner.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57821

D 57821

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gross

(a) RESIDENCE NO. 309 Fayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	B.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-9-21

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of Industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Seth Gross

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Carrie Gross

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Johns Hopkins Hospital (Address)

15 Filed OCT 13 1921, 19 [Robert P. Harrison,] 18588 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-9, 1921, to 10-11-, 1921, that I last saw him alive on 10-11-, 1921, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

10/13, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

OCT 13 1921

Rec. Wm. E. WOODALL

Burial Permit Issued

Spec.—1-10-21—M&T—1500 Blks.

D 57822 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57822

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Maryland Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Royster.

(a) RESIDENCE No. 1727 Md. Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE C

5 Single, ~~Married, Widowed~~, or ~~Divorced (write the word)~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 - 21

7 AGE Years Months Days If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —ddo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Royster

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Nancy Middleton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C

14 Informant
(Address) Robert P. Harrison.

15 Filed 1921 Burial Permit 16504 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1921.

17 I HEREBY CERTIFY, That I attended deceased from 10-16 .19 21. to 10-16 .19 21.
that I last saw him alive on 10-16 .19 21.
and that death occurred, on the date stated above, at 1.10 P m.
The CAUSE OF DEATH* was as follows:
prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Parsons M. D.
10/6 19 21 (Address) 3602 Forest Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS OCT 17 1921

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57823

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baylis Savage (Bailey Savage)

(a) RESIDENCE. NO. 1512 Shields Alley ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Savage

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 673

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Abel Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M. T. H.

15 Filed OCT 17 1921, 19 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 5, 19 21, to Oct. 13, 1921, that I last saw him alive on Oct. 13, 1921, and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T. B. in sputum, X-ray

(Signed) Frances L Badgley M. D.

10-13-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 18 1921
20 UNDERTAKER	ADDRESS
Daniel Easton	Lanvale

Spec.—8-24-14—M. & T.—2000 Bks.

D 57824

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 57824

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 635 Gorsuch ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Reed

(Residence in Baltimore: No. 635 Gorsuch St.; 56 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ? (Month) ? (Day) 1865 (Year)

7-AGE, 62 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Launderess
(b) General nature of industry, business, or establishment in which employed (or employer): OH

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, James Blackson

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Corinne Bellamy

(Address) 635 Gorsuch St

15-

Filed ..... 191 .....

Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept Oct 1921, to Oct 16 1921, that I saw h[illegible] alive on Oct 15 1921, and that death occurred, on the date stated above, at 3:20 a m.

The CAUSE OF DEATH* was as follows:

a .....

b Apoplexy

c ..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Paralysis

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) F. Dumler Harrison M. D.

Oct 16, 1921. (Address) 322 N Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Melitota Kent Co Md — DATE OF BURIAL, Oct 18th, 1921

20-UNDERTAKER Daniel Easton — ADDRESS 916 Penna ave

7 1921 Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 57825 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57825

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 Parish St ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Warner (Wanner)

(a) RESIDENCE NO. 439 Parish ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Warner.

6 DATE OF BIRTH (month, day, and year) Oct. 8-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Valentine Ambrosy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Dickman

(Address) 800 S. First.

15 7 1921 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1921, to Oct. 15, 1921, that I last saw h[illegible] alive on Oct. 13, 1921, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) James F. Hackney, M. D.

10/16, 1921 (Address) 1729 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Oct 18 1921

20 UNDERTAKER Lilly & Zuber

ADDRESS 403 S. Wolfe

THIS is very important. See instructions

Robert F. Harrison, [illegible]

D 57826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 D 57826

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 8 n Rose St. 6 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret n Condon

(Residence in Baltimore: No. 8 n Rose St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Aug 18 (Month) (Day), 1847 (Year)

7-AGE: 74 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Patrick ~~Condon~~ Casey

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Margaret Regan

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Condon

(Address) 8 N. Rose

15-

Filed ....., 191.....

Robert P. Harrison,

Burial Permit Clerk. Registrar.

1 7 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Hurley M. D.
(Coroner)

Oct 17, 1921 (Address) 29 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: New Cathedral Cem

DATE OF BURIAL, Oct 17, 1921

20-UNDERTAKER J. F. Moran

ADDRESS 300 E. Baltimore

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57827 D 57827

CERTIFICATE OF DEATH.

5 150

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 376 Forrest St. ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ursolina Volpetta.

(Residence in Baltimore: No. 376 Forrest St. St.: yrs. ---- mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH. October 12th. 1921., 1 (Month) (Day) (Year)

7-AGE. ---yrs.---mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Nathali Volpetta.

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Louisa Milazo.

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Volpetta. (mother)

(Address) 376 Forrest St.

15-

Filed ....., 191.... Registrar.

1 7 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 17th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

Oct. 17, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent Cemetery	Oct 17, 1921
20-UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

CAUSE OF DEATH important. See instructions on back of certificate.

D 57828

D 57828

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

144

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 938 Lanvale Ave ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Davis

(a) RESIDENCE. No. 938 Lanvale Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) DEC 12 13

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child (off)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Clarence Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Ethel Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant Clarence Davis
(Address) 938 Lanvale Ave

15 Robert P. Harrison 19

Registrar

Burial Permit Clerk

17 1921

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12 1921 to Oct 13 1921, that I last saw him alive on Oct 14 1921, and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows: Toxic

Femoral Injection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Leuk.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank E. Wagner M. D.

19 15. 19 (Address) 1076 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 18 1921
20 UNDERTAKER	ADDRESS 114 N
Brown & Freeland.	Schroeder

D 57829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital St. Ward) Registered No. C 170

2-FULL NAME Augustus S. Fitzell

(Residence in Baltimore: No. Kingsville) Md.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 19 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, July (Month) 10 (Day), 1898 (Year)

7-AGE, 23 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Truck Farm

9-BIRTHPLACE. (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER. Thomas R. Fitzell

11-BIRTHPLACE OF FATHER (State or Country). New Jersey

12-MAIDEN NAME OF MOTHER Rebecca Tomwiller

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy L. Fitzell

(Address) Kingsville Md

15-

Filed..... Robert F. Harrison; Registrar.

71921 Burial Permit Clerk.

Important. See instructions on back of Certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 15 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot fire accidently by self (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

10-16 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Kingsville Md.

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery

DATE OF BURIAL, Oct 18th, 1921

20-UNDERTAKER Fred'k Lassahn & Sons

ADDRESS Fullerton Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57830 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57830

CERTIFICATE OF DEATH. 32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 3 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie ~~Fiffoni~~ Ciffoni

(a) RESIDENCE. No. 906 Granby st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Parche Jackfone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Ladelia Pavino

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Hospital Records
(Address) M. T. H.

15 Filed 19 Robert F. Harrison, Registrar
7 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1921, to Oct. 16, 1921, that I last saw her alive on Oct. 16, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L Badaglia M. D.

10-16-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 18 1921
20 UNDERTAKER	ADDRESS
William J Schaefer	816 Monument

Spec.—1-10-21—M&T—1500 Blks.

D 57831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57831

CERTIFICATE OF DEATH.

X 45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospl ST., 75 WARD)

2-FULL NAME Frank Price.

(a) RESIDENCE NO. Elkton Md ST., WARD Elkton Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? Life 3 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Ella Price.

6 DATE OF BIRTH (month, day, and year) Jan 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Ella Price (Address) Elkton, Md

15 Filed Robert P. Harrison, Registrar

71921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-1-21 1921 to 10-17 1921.

that I last saw him alive on 10-17 1921

and that death occurred, on the date stated above, at 4 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder-
Cystitis Pyelitis - Chr. Nephritis -

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia - Pulmonary Oedema.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Exam.

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkton Md	Oct 17 1921
20 UNDERTAKER Wm J Pickerpaugh	ADDRESS North East Md

TION is very important. See instructions on

Spec. 6-9-19—H. P. Co.—1000 Bks.

D57832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D57832

154

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE. (NO. 945 S Paca St. ST.: 21 WARD)
(If death occurred in hospital or institution give its NAME instead of street and number.)

2-FULL NAME Louisa C. Lochner.

(a) RESIDENCE. NO. 945 S. Paca St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female. | 4 COLOR OR RACE: White. | 5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm M Lochner.

6 DATE OF BIRTH (month, day, and year) March 10 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76 yrs	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md.

PARENTS

10 NAME OF FATHER: Newport.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): dont know

14 Informant (Address): Fred Wallenmeyer. 2210 Hunter av

15 OCT 18 1921 ROBERT P. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1- 1921 to Oct 17 1921

that I last saw her alive on Oct 16 1921 at 7.58 a.m.

and that death occurred, on the date stated above, at 7. A.M.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation, hypostatic congestion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. mon. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical.

(Signed) Leo Friedlinger M. D.

Oct 19 1921 (Address) 682 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 19 1921
20 UNDERTAKER	ADDRESS
H. Thos. A. St. Paul's	1835 N. Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 150751
D 57833

CERTIFICATE OF DEATH.

1504 D 57833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 17 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Hutchinson

(a) RESIDENCE. No. 1811 Maryland Ave. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joe. Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Mamie Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 OCT 18 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1921.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1921. to Oct. 16, 1921.

that I last saw her alive on Oct. 16, 1921.

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Brain Tumor Ovar

(duration) about 6 mos

CONTRIBUTORY (Secondary) Respiratory paralysis

(duration) yrs. mos. ds. Short death

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Elcon Chesney, M. D.

10/17. 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 18 1921
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Division

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably congenital.

Lawson

D 57834

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

175 D 57834

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Lawson

(Residence in Baltimore: No. 1415 Penna Ave St. 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mard

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laber
(b) General nature of industry, business, or establishment in which employed (or employer) O+O

9-BIRTHPLACE. (State or Country). Va

PARENTS.

10-NAME OF FATHER, Wm Laston

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Anna Gray

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Laston

(Address) 1434 Penn ave

15-

FILED OCT. 18 1921 BOWERS & KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Skull by Auto (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. Knott Insley M. D.
(Coroner)

10-19-1921 (Address) Coroner's Office

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt auburn

DATE OF BURIAL, Oct 15, 1921

20-UNDERTAKER C C Gross

ADDRESS 1405 McElderry St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57835

CERTIFICATE OF DEATH.

104

D 57835

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Gleason

(a) RESIDENCE. No. Unknown. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3.	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant University Hosp Records

(Address) Fondaw & Grundy

15 OCT 18 1921 ROBERT P. KRAUSER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 13, 1921, to Oct 14, 1921,

that I last saw him alive on Oct 14, 1921,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute entero-colitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. C. B. Jones, M. D.

10/14, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick — DATE OF BURIAL: Oct 18 1921

20 UNDERTAKER: Mrs Mrs Ch & Sons — ADDRESS: 1135 N Gay

D 57836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9N D 57836

1-PLACE OF DEATH Municipal Hospitals ST. 22 WARD)

CITY OF BALTIMORE: (NO.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Mason

(a) RESIDENCE NO. 666 Haw st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Thomas Mason

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE — Years: 56 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED — 070

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): in family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Lew Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): —— Md

12 MAIDEN NAME OF MOTHER: Unknown

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hoff Bros (Address) 666 Haw st

15 Died Oct 18 1921 — ROBERT J. KRAUSE Registrar — Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-16-1921

17 I HEREBY CERTIFY, That I attended deceased from 10-13 1921, to 10-16 1921, that I last saw h alive on 10-16 1921 and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

(Address) Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt Auburn cemtry

DATE OF BURIAL: 10/19 1921

UNDERTAKER: J Leon Hall

ADDRESS 1741 D St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57837

CERTIFICATE OF DEATH. 28

D 57837

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Westwood Ave. ST., 15 WARD)

2-FULL NAME Lawrence Vorrath

(a) RESIDENCE NO. 1705 Westwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. - ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Vorrath

6 DATE OF BIRTH (month, day, and year) April-4-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	6	11	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Vorrath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Scholl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Margaret VOrath

(Address) 1705 Westwood Ave.

15 OCT 18 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct.-16-1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1921, to Oct. 16, 1921, that I last saw him alive on Oct. 14, 1921, and that death occurred, on the date stated above, at 1.40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 3 yrs. - mos - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum findings

(Signed) Merbin F Sloan M. D.

1017 1921 (Address) 414 Prof. Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct-19-1921

20 UNDERTAKER: Henry Hoerdt Son — ADDRESS: 1301 E Eager St

TION is very important. See instructions on

HEALTH DEPARTMENT—CITY OF BALTIMORE

5 57838

CERTIFICATE OF DEATH.

167 D 57838

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bal. Gen. Hosp. WARD) 21

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melissa Maud Kering

(Residence in Baltimore: No. Overlea, Md. St.; 37 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH, April 16, 1868
(Month) (Day) (Year)

7-AGE, 53 yrs. 6 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Bloomfield, Va

PARENTS.

10-NAME OF FATHER, Wm. Clouser

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Annie C. Clegg

13-BIRTHPLACE OF MOTHER (State or Country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. R. Kering

(Address) Overlea, Md

15 OCT 18 1921 191..... Filed

Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or enquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st, 2nd & 3rd degree burns of body, (accidental)
(Duration) yrs. mos. 14 hrs.

CONTRIBUTORY (Secondary) Burning clothes & dress caught fire
(Duration) yrs. mos. ds.

(Signed) J. C. T. Kenney M. D.
(Coroner.)

Oct. 17, 1921 (Address) 2802 Fleetwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death Bal. Gen. Hosp. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?
Overlea, Md.

Former or usual residence Overlea, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem	Oct. 18, 1921.
20-UNDERTAKER	ADDRESS
J. Kenney & Co H 1123	2008 Ave.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57839

1521 D 57839

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2233 Sherwood Ave ST. 9 WARD)

2-FULL NAME Richard M. Wilson

(a) RESIDENCE. No. 2203 Sherwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 16/21

7 AGE	Years	Months	Days	If LESS than 1 day 22 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John M. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary A. Reisl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John M Wilson 2203 Sherwood Ave.

15 OCT 18 1921 ROBERT J. KRAUER Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to Oct 17, 1921, that I last saw h[illegible] alive on Oct 17, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ephantiasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell M. D.

Oct 17, 1921 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Oct 18th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 57840

1-PLACE OF DEATH.
CITY OF BALTIMORE: No. 2023 Eagle ST.; 70 WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Morgan Jr.

(a) RESIDENCE. No. 2023 Eagle ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 9.3.21

7 AGE — Years: — Months: 1 Days: 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER James R. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER Stella Nowak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: James R. Morgan
(Address): 2023 Eagle St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10.16. 1921.

17 I HEREBY CERTIFY, That I attended deceased from October 16, 21 to October 16, 21

that I last saw him alive on October 16 - 21

and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

Malassimilation of Food (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) 1 yrs. 13 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test (bacteriological, microscopical, chemical, etc.) made? Clinical

(Signed) H. D. Meyer M. D.

(Address) 1019 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 18 1921

20 UNDERTAKER: John Stulds — ADDRESS: 1200 W Fayette

Burial Permit Given

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57841

CERTIFICATE OF DEATH.

41 D 57841

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 W. Fayette ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E. Gruntz

(a) RESIDENCE. No. 2515 W Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year): June 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Michael Money

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah A Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs Money 2515 W Fayette st

15 Filed , 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1920. to Oct 15 1921.

that I last saw her alive on Oct. 15 1921.

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 17, 1921

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) E. J. Bonchille M. D.

19 (Address) 210 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 19

20 UNDERTAKER: John J. Fields ADDRESS 1200 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

150

D 57842

CERTIFICATE OF DEATH.

D 57842

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Genevive Claire Beachum

(a) RESIDENCE: No. 4019 Park Heights Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 14, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Mercy Hospital

PARENTS

10 NAME OF FATHER Mr. Elijah Beachum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER — Pfeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elijah D. Beachum (Address) 4019 Park Heights Ave

15 Filed OCT 18 1921 19 Registrar

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1921, to Oct 17, 1921, that I last saw her alive on Oct 17, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Lesion 3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure 5 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Symptoms

(Signed) John J. Colvin M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 18 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 W. Lexington ST.; 20 WARD)

2-FULL NAME Charles A Rosenthal

(a) RESIDENCE. No. 2112 W Lexington ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mildred S Rosenthal

6 DATE OF BIRTH (month, day, and year): April 19/1873

7 AGE: Years 48 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Straw Hat

(b) General natore of industry, business, or establishment in which employed (or employer): Maker

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kate Wigley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mildred S Rosenthal
(Address) 2112 W. Lexington

15 Filed OCT 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1921, to Oct. 16, 1921, that I last saw him alive on Oct. 15, 1921, and that death occurred, on the date stated above, at 12 03 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Sputum Test.

(Signed) C. A. Dickey, M. D.

, 19 (Address) 14 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natore of Injury, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 19 19

20 UNDERTAKER: Wm Cade — ADDRESS: 502 E North Ave

C. Dickey 14 N Monroe

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57844 150 D 57844

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 N Charles ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Helen Dunkle

(a) RESIDENCE. NO. 1728 N. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. (1) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Harry B Dunkle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Edna M Walker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant H B Dunkle
(Address) 1725 N. Charles St

15 OCT 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Oct 18, 1921, that I last saw h- alive on Oct 17, 1921, and that death occurred, on the date stated above, at 4-30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes
Foramen Ovale
not closed.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. K. Fair, M. D.

, 19 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	10/19 1921
20 UNDERTAKER	ADDRESS
Wallace Cook	502 E N

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57845

CERTIFICATE OF DEATH.

D 57845

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1813 St. Paul st.

CITY OF BALTIMORE: (No. 1813 ST. Paul ST. WARD 17th)

2-FULL NAME Samuel Edwin Jump—

(a) RESIDENCE. NO. 1813 St. Paul ST., 18th WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Ina Jump—

6 DATE OF BIRTH (month, day, and year) July 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work U. S. Weigher 086
(b) General nature of Industry, business, or establishment in which employed (or employer) U. S. Gov.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vernon, Kent Co, Delaware.

PARENTS

10 NAME OF FATHER John Jump—

11 BIRTHPLACE OF FATHER (city or town) Queen Annes Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Graham

13 BIRTHPLACE OF MOTHER (city or town) Vernon, Kent Co (State or country) Delaware

14 Informant (Address) Mrs Ina Jump— 1813 St Paul st

15 Filed OCT 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1921, to Oct 16, 1921, that I last saw h— alive on Oct 16, 1921, and that death occurred, on the date stated above, at 3.45 p m.

The CAUSE OF DEATH* was as follows:
Hypertension, Arterio-sclerosis
Myocardial insufficiency
(duration) about 8 + yrs. mos. ds.

CONTRIBUTORY (Secondary) see above—arteriosclerosis
18 Nephritis (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no—

What test confirmed diagnosis? General medical examination—

(Signed) Louis Streett, M. D.

. 19 (Address) 712 Park Ave Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md. DATE OF BURIAL 10/19/21 19

20 UNDERTAKER H E Nagel Asst Sh Broadway ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57846 ✓ 50 D 57846

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. St.: 7 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Fortney

(a) RESIDENCE No. Burroughs, Montgalia Co. W Va Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter R. Fortney

6 DATE OF BIRTH (month, day, and year) 10-20-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Tim Riarx

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ettie Foote

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Baltimore

15 Filed OCT 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-10 , 1921 , to 10-17 , 1921 , that I last saw h[illegible] alive on 10-17 , 1921 , and that death occurred, on the date stated above, at 9.10 a m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Burroughs W Va.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Blood sugar & CO2

(Signed) B Herrman , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Piedmont W. Va	10/18/21 19

20 UNDERTAKER H E Hughes ADDRESS 1st & Broadway

57847

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 D 57847

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N. Gilmor ST. 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Anna Stanley,

(Residence in Baltimore: No. 714 N. Gilmor St. St.; 68 yrs. 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Dec 11 (Month) (Day), 1853 (Year)

7-AGE: 68 yrs 2 mos 6 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10-NAME OF FATHER: James Stanley

11-BIRTHPLACE OF FATHER (State or country): Balto. Md

12-MAIDEN NAME OF MOTHER: Amanda M. Jones

13-BIRTHPLACE OF MOTHER (State or country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Elizabeth Stanley
Mrs. J. C. Eby, M. D.

(Address) 714 N. Gilmor St

15- Filed OCT 18 1921

Burial Permit Issued

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October 17 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to, Oct. 14 1921, that I saw h.. alive on Oct 14 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Breast.

(Duration) 2 yrs 6 mos ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos ..... ds.

(Signed), Charles Eby M. D.

Oct 18, 1921 [Address] 1111 W. Lanvale St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Oct 19 1921

20-UNDERTAKER: George J. Smith — ADDRESS: 1060 Fayette St

57848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1921 D 57848

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 701 W. Mosher ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. H. Cronin

(Residence in Baltimore: No. 701 W. Mosher St.; 53 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, November (Month) 3 (Day) 1868 (Year)

7-AGE, 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm. M. Cronin

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Harriett E. Collins

13-BIRTHPLACE OF MOTHER (State or Country). Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Harriet E. Cronin

(Address) 712 W. 34th St. Phila. Pa

15 OCT 18 1921 Filed ..... 191.....

ROBERT J. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas (gas stove) about 2 hrs. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) accidental

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Oct 17. 1921 (Address) 201 E. Fayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Leuden Park Cemetery DATE OF BURIAL, Oct 19th 1921

20-UNDERTAKER Graham F. Walker ADDRESS 723 W Lafayette Ave

important. See instructions on back of certificate.

D 57849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 57849

64

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 831 Harlem Ave St. 17 WARD)

2 FULL NAME Rose C. M. Coyne

(Residence in Baltimore: No. 831 Harlem Ave. St.: a/e yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Sept. (Month) 14 (Day), 1845 (Year)

7 AGE 76 yrs. 1 mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Daniel McKenna

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Manus

13 BIRTHPLACE OF MOTHER (State or country) City Tyrone Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Coyne

(Address) 831 Harlem Ave

15 BORN & RECEIVED

Filed OCT 18 1921, 191 Baltimore Md.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 16 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aft. Sept. 1921, to Oct. 16 1921

that I saw h er alive on Oct. 16 1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis &
Hemiplegia

(Duration) 4 yrs. 6 mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Wm. B. Rider M. D.

Oct. 17, 1921 (Address) 86 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Cathedral | DATE OF BURIAL 10 19 1921

20 UNDERTAKER H. C. Manning Bro | ADDRESS 417 N. Schroeder St.

THE CAUSE OF DEATH must be properly examined. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57850

CERTIFICATE OF DEATH.

X 91-089

D 57850

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 619 N. Paca ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linell Connor

(a) RESIDENCE. NO. 619 N. Paca ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Easley Va
(State or country)

PARENTS

10 NAME OF FATHER Henry Connor

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Georgana Snoke

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Georgana Connor
(Address) 619 N. Paca St.

15 Filed OCT 18 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1921, to Oct. 15, 1921, that I last saw him alive on Oct. 14, 1921, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno B Robinson M. D.

(Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easley Va

DATE OF BURIAL Oct 18 1921

20 UNDERTAKER Daniel H Lemley

ADDRESS Baltimore

TION is very important. See instructions on

Burial Permit Clerk

Marion Zamenski

Spec.—6-9-19—H. P. Co.—1000 Bks.

57851 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57851

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hospital (St.:) 1 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Zamenski

(a) RESIDENCE. No. 911 S Curley St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 7 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Edward Zamenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Sosnoski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edward Zamenski

(Address) 911 S Curley

15 Filed OCT 18 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1921

17 I HEREBY CERTIFY, That I attended deceased from October 9, 1921 to Oct. 17, 1921

that I last saw h[illegible] alive on October 17, 1921

and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of Oct 9, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Schumacher M. D.

, 19 (Address) St Joseph's Hosp. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 20 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bard

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for empyema
not tuberculous. History of
lobar pneumonia.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57852

CERTIFICATE OF DEATH.

GD 57852

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2335 Frederick Ave St.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Spencer Barbour
Barbour.

(Residence in Baltimore: No. 2335 Frederick av St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, white

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, Nov 20th, 1871
(Month) (Day) (Year)

7-AGE, 49 yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... yes.

9-BIRTHPLACE, (State or Country), Frederick Co. Md.

PARENTS.

10-NAME OF FATHER, Charles B. Barbour

11-BIRTHPLACE OF FATHER (State or Country), Frederick Co Md

12-MAIDEN NAME OF MOTHER Anna Elizabeth Liddlesoner

13-BIRTHPLACE OF MOTHER (State or Country), Middletown Frederick Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. E. Glenn

(Address) 2335 Frederick Ave

15- Filed OCT 18 1921 191... [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16th 1921, to Oct 17th 1921, that I saw h[illegible] alive on Oct 17th 1921, and that death occurred, on the date stated above, at 1 30 Am

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

(Duration)..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Exposure

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) Frank S. Hundley M. D.

....., 191... (Address) 2512 Maryland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park. DATE OF BURIAL, Oct. 19, 1921.

20-UNDERTAKER George L. Schwab ADDRESS 201 Fredk Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57853

CERTIFICATE OF DEATH.

151 D 57853

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 McCulloh ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Willis

(a) RESIDENCE. No. 226 McCulloh St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15-1921

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) 226 McCulloh St
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Floyd

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Evelyn Willis

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Evelyn Willis
(Address) 226 McCulloh St

15 Filed OCT 18 1921 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15- 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/15- 1921, to 10/15- 1921, that I last saw h alive on 10/15- 1921, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
is the only cause I can find

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Was a Premature Birth

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Benj Floyd, M. D.

. 19 (Address) 1 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Oct 18 1921
20 UNDERTAKER	ADDRESS
Edward Ringgold	1463 Carey C.

D 57854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Eighteen foot 4 Woodall St or Hospital St. 22 WARD)

REGISTERED No. C 1772

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2-FULL NAME C. C. Smith

(Residence in Baltimore: No. 111 W. Lee St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman Dry
(b) General nature of industry, business, or establishment in which employed (or employer): Maker 086

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Scanlan

(Address) 1720 St Paul St

15- OCT 18 1921 191.. BOTHET & KRAUTZ Burial Form (Rev) 1922

Cause of death must be stated in full. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull and Internal injuries due to accidental fall

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carroll ..... M. D.
(Coroner)
Oct 17, 1921. (Address) 1639 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Norfolk Va	Oct 18, 19..
20-UNDERTAKER	ADDRESS
John F Dalrymple	316 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57855

CERTIFICATE OF DEATH.

92 D 57855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 703 Pennington ave ST.; 13 WARD)

2-FULL NAME Mary M. Lauer

(a) RESIDENCE. NO. 703 Pennington ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Lauer

6 DATE OF BIRTH (month, day, and year): Jan 27, 1848

7 AGE — Years: 72 — Months: 9 — Days: 21 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Ed. E. Conoway

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Elizabeth A. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Nettie Clark (Address) 703 Pennington ave

15 Filed Oct 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Oct 18, 1921, that I last saw h[illegible] alive on Oct 17, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D

Oct 18, 1921 (Address) 720 E. Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: Oct. 20 1921

20 UNDERTAKER: Fickler & Fickler — ADDRESS 1739 Eager

TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57856 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 57856

✓

79

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1406 N. Central ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lida Valiant

(a) RESIDENCE. No. 1406 N. Central ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of N. V. Valiant

6 DATE OF BIRTH (month, day, and year) Oct. 25 1839

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Francis Botterill

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geo. B. Gibson
(Address) 1406 N. Central ave.

15 Filed [illegible] 19

Registrar

Burial Permit Clerk.

8 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14. 1920. to Oct. 16. 1921.

that I last saw her alive on " 15. 1921.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

Oct. 17, 1921 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	Oct. 19 1921

20 UNDERTAKER — ADDRESS

Wm. C. Black — 927 N. Bowdry.

Spec.—6-2-19—H. P. Co.—1000 Bks.

D 57857

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57857

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME allen Henry

(a) RESIDENCE. NO. 1238 E. Fort Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Euphemia~~ Mrs. A. Henry

6 DATE OF BIRTH (month, day, and year) Nov. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 032

(b) General nature of industry, business, or establishment in which employed (or employer) City fire Department

(c) Name of employer City Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Euphemia ~~Henry~~ Hunsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. A. Henry. (Address) 1238 E. Fort Ave

15 Filed Robert P. Harrison, Registrar

8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15th 1921 1 PM to 8 P.M.

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1921, to Oct 15th, 1921, that I last saw him alive on Oct 15th, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) 7 years mos. ds.

CONTRIBUTORY (Secondary) Chronic Nat. Arterio Sclerosis

(duration) yrs. mos. ds. Chronic art. Hypertension

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nesta de Cardova M. D.

. 19 (Address) M.d. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Oct. 18 1921
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1432 Light St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57858 D 57858

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1210 N Caroline ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Solter

(a) RESIDENCE NO. 1210 N Caroline ST, ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 6 mos. 28 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Solter

6 DATE OF BIRTH (month, day, and year) Nov 19 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Isaac Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo A Solter

(Address) 1210 N Caroline St

15 8 1921 Robert P. Harrison, 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 9, 1921, to Oct 17, 1921, that I last saw her alive on Oct 17, 1921, and that death occurred, on the date stated above, at 1450 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? tests for sugar

(Signed) R G Davis, M. D.

, 19 (Address) 1509 Harlem Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Ridge Com	Oct 19 21
20 UNDERTAKER	ADDRESS
W J Fitzpatrick Sons	Hatt 16

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57859 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 14 WARD) 50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward B. Green

(a) RESIDENCE NO. 1400 Ontario Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winnie L. Green

6 DATE OF BIRTH (month, day, and year) 9-23-61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	25	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Special Agent Fidelity

(b) General nature of industry, business, or establishment in which employed (or employer) Guarantee & Trust Co

(c) Name of employer U.S. F. & G. Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed 8 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18 1921

17

I HEREBY CERTIFY, That I attended deceased from 9-17 1921 to 10-18 1921

that I last saw him alive on 10-18 1921

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Benign prostatic Hypertrophy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/18/21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene B. Shaw, M. D.

10/21, 1921 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 19 1921
20 UNDERTAKER J. & B. Cook	ADDRESS 1032 W. Balto

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 57860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 109 D 57860

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia King

(a) RESIDENCE. NO..... St., Agnes Hospital ST., WARD. Halethorpe, Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David King

6 DATE OF BIRTH (month, day, and year): Dec. 27th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Henry Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Bessie F. King

(Address): Relay Md.

15 Filed: 1 8 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1921, to Oct. 15 1921, that I last saw h.. alive on Oct. 5 1921, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH was as follows:

Intestinal Obstruction

(duration) yrs. mos. 24 hrs.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 3 hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/15/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W C Caldwell M D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Co	Oct 18 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Gay St.

TION IS very important. See instructions on

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57861

D 57861

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Oakley ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert A. Hutchinson

(a) RESIDENCE. No. 2005 Oakley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Virginia Hutchenson

6 DATE OF BIRTH (month, day, and year) Dec 25, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Locomotive Engineer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Robert A. Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Sarah E. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs. Sadie Cassell
(Address) 2005 Oakley St.

181921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1919, to October 17, 1921, that I last saw h. alive on October 17, 1921, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Hemiplegia

(duration) 3 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical findings

(Signed) J. H. M. Cliff M. D.

10/17 1921 (Address) 1312 N. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 19 1921

20 UNDERTAKER R. B. Cook

ADDRESS 1003 [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57862

CERTIFICATE OF DEATH.

D 57862

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Patapsco ST.: 23 WARD)

REGISTERED NO. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. C. Parks

(Residence in Baltimore: No. 1604 Patapsco St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the Word.) Single

6-DATE OF BIRTH, February 21st, 1903
(Month) (Day) (Year)

7-AGE, 18 yrs. 7 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer) Holtz Bakery

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles E Parks.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Katherine Scherder

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E Parks.

(Address) 1604 Patapsco St

15-

Filed ....., 191....

Robert P. Harrison,

Registrar.

1 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1921, to Oct 16 1921, that I saw h alive on Oct 16 1921, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

I. Pulmonary Tuberculosis

Progressive

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. 2 ds.

(Signed) R. E. Campbell M. D.

Oct 17, 1921. (Address) 1664 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross a.a.Co. DATE OF BURIAL, 10-19, 1921.

20-UNDERTAKER E & B Harle ADDRESS 115 E West St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gass

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57863

CERTIFICATE OF DEATH.

X 40 ✓

D 57863

1-PLACE OF DEATH Howard A. Kelly Hospital

CITY OF BALTIMORE: (NO. Well ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Gass

(a) RESIDENCE. NO Washington D C ST., WARD. Washington D.C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada C. Gass

6 DATE OF BIRTH (month, day, and year) about Jan 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Purchasing Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Gass (Address) Washington D.C.

15 OCT 19 1921 [illegible] Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1921, to Oct 18, 1921, that I last saw h[illegible] alive on Oct 18, 1921, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma left lobe liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No ✓

What test confirmed diagnosis? Phys. Exam

(Signed) Arthur C. Primrose, M. D.

10/18, 1921 (Address) 1418 Cantaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Oct 19 1921

20 UNDERTAKER Mrs. J. E. Evans & Sons ADDRESS 1428 Charles St

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57864

CERTIFICATE OF DEATH.

113

D 57864

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 133 N. Ann ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Lancaster

(a) RESIDENCE. NO. 133 N. Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Benjamin Lancaster

6 DATE OF BIRTH (month, day, and year): July 20 1867

7 AGE — Years: 54 Months: 2 Days: 27 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House - wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Burkhard Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md -

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md -

14 Informant (Address): Benjamin Lancaster 133 N. Ann

15 OCT 19 1921 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 - 1921, to Oct 17, 1921.

That I last saw h[illegible] alive on Oct 17, 1921.

and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. few ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver & Kidneys (duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L A Richardson M. D.

Oct 18 1921 (Address) 117 N. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem. — DATE OF BURIAL: Oct. 20th 1921

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans St.

Burial Permit Clerk

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

57865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57865

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 2401 Harlem Ave. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Itzel

(a) RESIDENCE. NO. 2401 Harlem Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~WIFE of~~: Barbara Itzel

6 DATE OF BIRTH (month, day, and year): May 25-1843

7 AGE — Years: 78 Months: 4 Days: 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0.86

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: John Itzel (Address) 2401 Harlem ave

15 OCT 19 1921 ROBERT J. KRAUTER Registrar Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9 1921, to Oct. 16 1921, that I last saw him alive on Oct. 16 1921, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of internal Capsule of Right Brain. Hemiplegia

(duration) yrs. 7 ds.

CONTRIBUTORY (Secondary): ~~Hypo~~ static Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Caralysis of Left Side

(Signed) Thos. H. Phillips, M. D.

, 19 (Address) 2300 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Oct 19 1921

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

Nicol

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 57866 HEALTH DEPARTMENT—CITY OF BALTIMORE 41 D 57866

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 1708 St Paul. ST. 12 WARD)

2-FULL NAME John William Nicol

(a) RESIDENCE. No. 1708 St. Paul St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Nicol

6 DATE OF BIRTH (month, day, and year) aug 11, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk = 009

(b) General nature of industry, business, or establishment in which employed (or employer) Record Office

(c) Name of employer City of Balto.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER David Nicol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah A. Farlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary V. Otte (Address) 1708 St Paul St

15 OCT 19 1921 ROBERT F. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16. 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Oct 16, 1921, that I last saw h in alive on Oct 16, 1921, and that death occurred, on the date stated above, at 11.58 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Probably of malignant origin) (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute heart failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm F Krauter M. D.

Oct 16 1921 (Address) 2124 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Oct. 19 1921

20 UNDERTAKER John Mitchell ADDRESS 1201 W. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57867

CERTIFICATE OF DEATH.

79 D 57867

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 S. Fifth ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Geusler.

(a) RESIDENCE. No. 805 S. Fifth ST., N WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Geusler.

6 DATE OF BIRTH (month, day, and year) Oct 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Hammelman

(Address) 805 S. Fifth St.

15 OCT 19 1921 ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1921, to Oct 16, 1921, that I last saw her alive on Oct 15, 1921, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial Dis - sufficiency (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. A. Reifschneider M. D.

10/17, 1921 (Address) 340 S. Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Oct 19 1921
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe St.

THIS is very important. See instructions on

D 57868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159 D 57868

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2016 Mt. Royal Terrace ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Taylor Sauerwein

(Residence in Baltimore: No. 2016 Mt. Royal Terrace St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, January (Month) 12 (Day), 1870 (Year)

7-AGE, 51 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mgr. Sales Agent
(b) General nature of industry, business, or establishment in which employed (or employer): for Lumber Industry

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edw. A. Sauerwein

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Annie Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Allen Sauerwein (Brother)

(Address) Lexington Building

15- Filed OCT 19 1921 ROBERT J. KRAUSE Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Gun Shot wound thro ph head Suicide

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 17 1921 (Address) 3632 Roland Ave

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? 0

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Oct 19 1921

20-UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. WOODLIN, Manager)

ADDRESS 108 W. NORTH AVE

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57869

CERTIFICATE OF DEATH.

4 D 57869

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3925 Fisley St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustine A. Farber

(a) RESIDENCE. No. 3925 Fisley St ST., 9 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 60 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) about 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) unknown Germany

PARENTS

10 NAME OF FATHER John M Farber

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Fisley

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Germany

14 Informant Wm Edw. F. Farber (nephew)

(Address) 925 N. Caldwell St.

15 FILED OCT 19 1921 ROBERT I. FRAZIER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1921, to Oct 18, 1921, that I last saw h[e] alive on Oct 17, 1921, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas A Clarke M. D.

, 19 (Address) 1501 N Caldwell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Oct 19, 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 166 W. NORTH AV

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 57870

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Fulton Av ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vida Rother Mahon

(a) RESIDENCE. No. 808 N. Fulton Av ST., 16 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? 44 yrs. 8 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Mahon

6 DATE OF BIRTH (month, day, and year) January-21-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robt M. Rother

11 BIRTHPLACE OF FATHER (city or town) not known
(State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Douglas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. W. F. Mahon (husband)
(Address) 808-N-Fulton ave

15 OCT 19 1921 BOBBIT & KRAUSER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from May. 13. 1921, to Oct. 17. 1921, that I last saw h alive on Oct. 17. 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Staphylococcus Albus infection

(duration) yrs. 5½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture.

(Signed) Martin Wilhoit M. D.

. 19 (Address) 1067 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 20 1921
20 UNDERTAKER Stewart & Mowen Company (William F. Wooden, Successor)	ADDRESS 108 W. North Ave.

TION is very important. See instructions on back of certificate.

(Scheinin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57871 | 001 | 175 | D 57871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 18 WARD) REGISTERED No. C

2-FULL NAME Leon B. Scheinin

(Residence in Baltimore: No. 5 S. Carey (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

13 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH Dec 5, 1869
(Month) (Day) (Year)

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Tailor (Ladies)
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Dunkan

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Dunkan

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore St

15- FILED OCT 19 1921 ROBERT A KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Murder (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) W. L. Riley M. D.
(Coroner.)

Oct 19, 1921 (Address) 1439 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Woodmen Circle	10/19, 1921
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balt St

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57872

CERTIFICATE OF DEATH.

18 D 57872

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St Hospital St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Nelson L Cook

(Residence in Baltimore: No. 1104 Burgundy alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Married

6-DATE OF BIRTH, Oct (Month) 17 (Day) 1897 (Year)

7-AGE, 24 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scrapper 073
(b) General nature of industry, business, or establishment in which employed (or employer): Ludwig Kruck

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm H Cook

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Mary M Magoha

13-BIRTHPLACE OF MOTHER (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. Cook

(Address) 111 Ridgely

15- OCT 19 1921 191 ROBERT E KRAUTZ Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound through Lungs

murder

(Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) yrs. mos. 1/2 ds.

(Signed) James H Fenlon M. D.
(Coroner.)

Oct 19, 1921. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Balto & Hen Carrollton ave

Former or usual residence 1104 Burgundy alley

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western	Oct 19, 1921

20-UNDERTAKER	ADDRESS
John J Fields	1200 N Fremont St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Levin D. Woolford
40

D 57873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Mc Cubbin St.: 6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levin D. Woolford

(a) RESIDENCE. No. 1715 Mc Cubbin St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widower

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Mrs Annie Woolford

6 DATE OF BIRTH (month, day, and year) ~~unknown~~ ~~1846~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	~~unknown~~	~~unknown~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod-Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 035

(c) Name of employer Fred Slade (Contractor)

9 BIRTHPLACE (city or town) (State or country) Chester Co, Md.

PARENTS

10 NAME OF FATHER Linton Woolford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucinda Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel Woolford (sister)
(Address) 1218 Mc Elderry St.

15 Filed OCT 1 1921 J C Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/17 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/14, 1921, to 10/17, 1921, that I last saw him alive on 10/16, 1921, and that death occurred, on the date stated above, at 1.50 A.m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) General debilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Ralph J. Young M. D.

. 19 (Address) 1429 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Oct 20 1921
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Division

TION is very important. See instructions on the back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57874

CERTIFICATE OF DEATH.

43 ✓

REGISTERED NO. D 57874

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 203 E 20½ St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary G McLain

(a) RESIDENCE. No. 203 E 20½ St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William McLain

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of Industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer J G Marshall

Lit L. Balt-28 Forrestal Sbow

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER ~~Ret~~ Perber Oden

11 BIRTHPLACE OF FATHER (city or town) (State or country) NC

12 MAIDEN NAME OF MOTHER Lou Oden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) NC

14 Informant Pearl Plowden

(Address) 203 20½ St

15 OCT 19 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/17/21

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to Oct 17, 1921,

that I last saw h.r alive on Oct. 17, 1921,

and that death occurred, on the date stated above, at 12.20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(duration) ? yrs. 10 mos. ? ds.

CONTRIBUTORY (Secondary) unknown

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Geo. H. Hall, M. D.

, 19 (Address) 1266 23 Dot,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 19 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57875

CERTIFICATE OF DEATH.

20 D 57875

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home ST.: 6 WARD)

2-FULL NAME Charles A. Hoffmann.

(a) RESIDENCE. No. 2240 E. Balto ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or, ~~WIFE~~ of) Mary E. C. Hoffman

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frederick Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jos. J. Fitzgerald of G. (Address) 307 Harlowe av.

15 OCT 19 1921 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/1921

17 I HEREBY CERTIFY, That I attended deceased from 10/16/1921, to 10/19/1921, that I last saw him alive on 10/18/21, 19—, and that death occurred, on the date stated above, at 2.25 a. m.

The CAUSE OF DEATH* was as follows:

Abscess, parotid gland (left)
Septicaemia?
(Secondary Anaemia)

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) ① Carcinoma ② Nephritis (duration) ① 4 ② 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. B. Kreale, M. D.

10/19, 1921 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 21 19 21
20 UNDERTAKER	ADDRESS
Louis Heeman	325 Broadway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57876

REGISTERED NO. 120 D 57876

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 684 Columbia ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Stumpf

(a) RESIDENCE. No. 684 Columbia ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or Divorced ~~(write the word)~~
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Stumpf

6 DATE OF BIRTH (month, day, and year) Feb 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Caspar Stumpf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ethnie Stumpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John K. Stumpf 1934 N. Fayette St

15 Filed OCT 19 1921 19 ROBERT P. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921 to Oct 17 1921 that I last saw him alive on Oct 16 1921 and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis 1- (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Alb Smeiger M. D.

10/17/21 (Address) 682 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Augustine Elkridge	Oct 20 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Bdwy

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 57877

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 ✓ D 57877

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 223 W. Hill St. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Henry. (C)

(Residence in Baltimore: No. 223 W. Hill St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Divirced.

6-DATE OF BIRTH, Do not know (Month), 1 (Day), ... (Year)

7-AGE. 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Jonas Henry. (C)

11-BIRTHPLACE OF FATHER (State or Country). Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER Sarah A. Stafford. (C)

13-BIRTHPLACE OF MOTHER (State or Country). Dorchester Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin L. Henry. (C) brother.

(Address) 702 Eislan St.

15- OCT 19 1921 ROBERT J. KRAUTER Registrar of Vital Statistics. Burial Permit Issued

CAUSE OF DEATH must be filled in. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17th. 1921 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Einhorn M. D. (Coroner.)

Oct. 18th 1921 (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Interment ✓	Oct 20 ..., 19...
20-UNDERTAKER L. E. Brauer's Son	ADDRESS 1611 W. Pratt St

Spec.—1-10-21—M&T—1500 Bks.

D 57878 HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 57878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. J. Eckert

(a) RESIDENCE NO. St. Vincents Inf Asy ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	Mo		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Wm J Eckert

11 BIRTHPLACE OF FATHER (city or town) Do Not Know.
(State or country)

12 MAIDEN NAME OF MOTHER K. Fahlinger

13 BIRTHPLACE OF MOTHER (city or town) Do not know.
(State or country)

14 Informant Mrs. K. Eckert
(Address) St Vincents Inf. Asy

15 OCT 19 1921 ROBERT I KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-18 1921 to 10-19 1921

that I last saw h[illegible] alive on 10-19 1921

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Not Known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. Vincents Inf. Asy.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. V. Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Oct 9 192[illegible]

20 UNDERTAKER Martin P. Cahey & Son ADDRESS 827 W Pratt St

CAUSE OF DEATH to be given on back of certificates.
TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sjolander

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57879

50 D 57879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward O. F. Jolander -

(a) RESIDENCE. No. 4105 Bateman ave ST.: City WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W -

5 (Single,) Married, Widowed, or Divorced (write the word): 5

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: 8 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy -

(b) General nature of industry, business, or establishment (in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City -

PARENTS

10 NAME OF FATHER Rogner S Jolander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden -

12 MAIDEN NAME OF MOTHER Ida Kelly -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto -

14 Informant Ida Sjolander

(Address) 4105 Bateman Ave

15 Filed OCT 19 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-16, 1921, to 10-18, 1921, that I last saw h Im alive on 10-18 -, 1921, and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Acidosis -
Diabetes Millitus
3 days - (duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Diabetes
(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) W B Jones, M. D.

19, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Parker	Oct 21 1921
20 UNDERTAKER	ADDRESS
E. A. Windfield Jr	501 E 25th

TION is very important. See instructions on back

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 57880 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57880

CERTIFICATE OF DEATH. 429

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Nichols

(a) RESIDENCE. NO. Upper Fairmount Md WARD. Upper Fairmount Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, (Married,) Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Nichols.

6 DATE OF BIRTH (month, day, and year): Nov 1888

7 AGE: Years 33; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farm Laborer

(b) General nature of industry, business, or establishment in whirh employed (or employer): Farming

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Upper Fairmount Md.

PARENTS

10 NAME OF FATHER: Chas Nichols.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Upper Fairmount Md.

12 MAIDEN NAME OF MOTHER: Margaret Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Upper Fairmount Md

14 Informant (Address): University Hosp Md.

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

CT 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/19 1921, to 10/17, 1921, that I last saw h[illegible] alive on Oct 17, 1921, and that death occurred, on the date stated above, at 11.50 am m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary tuberculosis.

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary): Tuberculous cystitis.

(duration) yrs. 5, mos. ds.

18 Where was disease contracted if not at place of death? Upper Fairmount Md

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical finding

(Signed) K B Jones, M. D.

Oct, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Lawn Md — DATE OF BURIAL: Oct 19 1921

20 UNDERTAKER: Saml Hensley — ADDRESS: 578 N Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill every item. Use ditto marks only when they will not be misunderstood. Read carefully the instructions on back of certificates. TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

D 57881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57881

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.; 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Francis Hawkins

(Residence in Baltimore: No. St Elizabeth's Home St.: ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	Negro	

6-DATE OF BIRTH, August 24, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....NONE.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Sent by the Hunter Supervisor of city charities from Juvenile Court

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed ....., 191....

Robert P. Harrison,
Burial Permit Clerk, Registrar.

OCT 1 1921

18500

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 16 1921, to October 17 1921, that I saw h[illegible] alive on October 17 1921, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

(a) Tantrum Entiniatis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank J. Ayd M. D.

Oct 18, 1921 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL, ..., 191....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57882

120 D 57882

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2112 N. Charles ST., 17 WARD)

2-FULL NAME Ada alford

(a) RESIDENCE NO. 2112 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Han. e alford.

6 DATE OF BIRTH (month, day, and year) Unknown 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer) D27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Thomas Jackson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Han. E. alford (Address) 2112 N. Charles St

15 Filed ..., 19... Registrar Robert P. Harrison, Burial Permit Clerk.

9 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19 19... to Oct 18 1921.

that I last saw h[illegible] alive on Oct 18 1921.

and that death occurred, on the date stated above, at 1135 a m.

The CAUSE OF DEATH* was as follows:

Acute nephritis (uraemia) (duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? Urinalysis

What test confirmed diagnosis? Blood pressure

(Signed) [illegible] M. D.

Oct 19 21 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon. Pk.

DATE OF BURIAL Oct 20 1921

20 UNDERTAKER Wm. Cook.

ADDRESS 502 E. North ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57883

CERTIFICATE OF DEATH.

D 57883

9

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) 2206 Guilford Ave (b) 12 (c) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola G Marks

(a) RESIDENCE. No 2206 Guilford Ave WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 21/1918

7 AGE: Years 3 Months 9 Days 27

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James E Marks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Minnie D Calvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): James E Marks 2206 Guilford Ave

15 Filed 19 Robt. P. Harrison, Registrar

1921

Bacon 1008 20th St Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1921, to Oct 19, 1921, that I last saw h. alive on Oct 19, 1921, and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (over)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Tests

(Signed) Walter C Bacon, M. D.

10/19 1921 (Address) 1008 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 20 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North Ave

TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Laryngeal

Spec.—1-10-21—M&T—1500 Bks.

D 57884 HEALTH DEPARTMENT—CITY OF BALTIMORE 45 D 57884

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Ave. near Radecke Ave. ST., 18 WARD) Raspeburg

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Hofstetter

(a) RESIDENCE NO. Franklin near Radecke Ave. ST., WARD Raspeburg
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Hofstetter

6 DATE OF BIRTH (month, day, and year) April 18th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Hofstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Lutz

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Bertha Hofstetter (Address) Raspeburg Md

15 Oct 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Oct 17, 1921, that I last saw him alive on Oct 17, 1921, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bladder

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Lutz M. D.

(Address) 2764 Linford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 20 1921
20 UNDERTAKER	ADDRESS
Frank Lasanby Sons	Fullerton

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57885

CERTIFICATE OF DEATH.

170

D 57885

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 E. Preston ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Ungland

(a) RESIDENCE No. 907 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Marab. D. Ungland

6 DATE OF BIRTH (month, day, and year) Sept 10 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	74.	1.	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John W. Ungland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ungland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Marab. D. Ungland

(Address) 907 E Preston

15 Filed 19 Robert F. Harrison, Registrar

1 9 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 19 19, to Oct 18, 1921, that I last saw him alive on Oct 18, 1921, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cystitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Hubert C. Kemp, M. D.

(Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount. DATE OF BURIAL Oct 21 1921

20 UNDERTAKER Wm Cook ADDRESS 1502 E. Monument

SEE IMPORTANT NOTICE on back of certificates. SECTION is very important. See instructions on

Stmc.—6-9-19—H. P. Co.—1000 Bks.

D 57886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57886

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH
CITY OF BALTIMORE. (No. 1745 East Lexington St.; 5 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine E. Gross.

(a) RESIDENCE. NO. 1745 East Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 29 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Laurence Gross
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Landberg
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Elizabeth C. Smith
(Address): 1745 E Lexington

15 Filed 10-19 1921 Robert P. Garrison, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to Oct. 17, 1921, that I last saw h[illegible] alive on Oct. 17, 1921, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

10-18, 1921 (Address) 120½ Aisquith st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery
DATE OF BURIAL: Oct 20 1921

20 UNDERTAKER: William Cook
ADDRESS: 502½ North

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57887

CERTIFICATE OF DEATH.

18 D 57887

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 112 E Cross ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Stell Gore

(a) RESIDENCE. NO..... 112 E Cross ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 18 mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Gore

6 DATE OF BIRTH (month, day, and year) July 8 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Charles Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Frank N Gore (Address) 112 E Cross St

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

91921

Via. B & O. R.R. c/o Frank N. G

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 14 ....., 1921, to Oct 18, 1921, that I last saw h.r alive on Oct 18, 1921, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Child birth Aug 14/21 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J M Le Cates, M. D.

10/18 1921 (Address) 319 High St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Oct 20 1921

20 UNDERTAKER W. L. Cook

ADDRESS 512 E Race

TION is very important. See instructions on BACK OF CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

151223

D 57888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57888

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Wilhelm.

(a) RESIDENCE. No. 3523 Parkdale Ave. Woodberry, City
(Usual place of abode) ST. WARD.

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence C. Wilhelm (Husband)

6 DATE OF BIRTH (month, day, and year): Oct. 8, 1900.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. - W. 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10 NAME OF FATHER: Arthur Butler.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Indiana.

12 MAIDEN NAME OF MOTHER: Mattie L. Hard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana.

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 . 19 Registrar

9 1921

Burial Permit Clerk.

c/o Clarence Wilhelm Via Brooklyn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1921 to Oct 18, 1921, that I last saw her alive on Oct 18, 1921, and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Subacute Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Subacute Tonsilitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 18, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leo Brody, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crownell Ind Indianna	Oct 20 1921
20 UNDERTAKER: Wm Cook	ADDRESS: 502 E. North

TION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57889

CERTIFICATE OF DEATH.

37 ✓ D 57889

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Grace

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 FILED OCT 20 1921 ROBERT I. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7 1896, to Oct. 17, 1921, that I last saw him alive on October 17, 1921, and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) See other side

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

10/18/21 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Oct 21 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57890

CERTIFICATE OF DEATH.

79-191 D 57890

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Esplanade apt ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew D. Hessberg.

(a) RESIDENCE. No. Entaw Place Druid Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Hessberg.

6 DATE OF BIRTH (month, day, and year) Jany 28/1802

7 AGE	Years	Months	Days	LESS than 1 day, hrs. or min.
	69	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale

(c) Name of employer Tryon

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Isaac Hessberg.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Gumpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ben Hessberg (Address) Esplanade

15 OCT 20 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1921, to October 19, 1921, that I last saw him alive on October 19-21, 19 , and that death occurred, on the date stated above, at 3.12 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular (aortic) heart disease

Myocardial degeneration

(duration) 10 yrs.+ mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Charles L. Austrian, M. D.

, 19 (Address) 1417 Entaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Oct 21st 1921

20 UNDERTAKER David Sondheim ADDRESS 118 N Mkt

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57891

D 57891

152

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Baby Horn

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 0 ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19, 1921

7 AGE	Years	Months	Days	If LESS than 1 day 5½ hrs. or ..... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Irving B Horn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elsa Strouse

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Indiana

14 Informant Mrs H.W. Strouse
(Address) Lake Court Apt

15 Filed OCT 20 1921 ROBERT J. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1921, to Oct 19, 1921, that I last saw h[illegible] alive on Oct 19, 1921, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Atlectasis of Lungs

(duration) yrs. ..... mos. 5½ hrs ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? None

What test confirmed diagnosis? None - Physical Examination

(Signed) Norman E Tannenbaum, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bath Haven — DATE OF BURIAL Oct 20 1921

20 UNDERTAKER David Bowden — ADDRESS [illegible]

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57892

D 57892

151

CERTIFICATE OF DEATH

1-PLACE OF DEATH Robert Garrett Hospital for Children REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Marsh

(a) RESIDENCE. No. 117 S. Carey ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 30, 1921

7 AGE — Years: — Months: 1 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Louis Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Phoebe Colhouer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs. Phoebe Marsh

(Address): 117 S. Carey St.

OCT 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1921, to Oct 19, 1921, that I last saw h 21 alive on Oct 18, 1921, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mos)

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. V. Clift, M. D.

10/19, 1921 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 20" 1921

20 UNDERTAKER: Edgar B. Cook — ADDRESS: 603 N. Bal[illegible] St.

THIS is very important. See instructions on back of certificate.

D 57893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 57893

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1110 Munsey Building. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Key. 60 ------- St.; yrs., mos. ds.)

(Residence in Baltimore: No. 1722 Hollins St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, January 1st. 1849, 1
(Month) (Day) (Year)

7-AGE, 72 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Broker. 88
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Howard Co. Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Key. (wife)

(Address) 1722 Hollins St.

15- OCT 2 0 1921

Filed ..... 191.... [illegible] Registrar.

Burial Permit Oleck

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17th. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.
Pulmonary Tuberculosis.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) H. W. Leonard (Coroner.) (M. D.

Oct. 18th. 1921 (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem. DATE OF BURIAL, Oct 20, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57894

CERTIFICATE OF DEATH.

79-091

D 57894

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cor. Forrest Chas ST.; 10 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Maria Uncles

(Residence in Baltimore: No. St Frances Convent ST.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1836 (Year)

7-AGE,	If LESS than 1 day,
85 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records

(Address) St. Frances Convent

15-

Filed OCT 20 1921 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1921, to Oct 18 1921, that I saw her alive on Oct 17 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

1. .....
2. Lobular Pneumonia
3. .....

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Mary F Donahue M. D.

Oct. 20, 1921. (Address) 102 N Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Oct. 21, 1921
20-UNDERTAKER	ADDRESS
John B Payz	102 E. Mulberry St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57895

CERTIFICATE OF DEATH.

9 V D 57895

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 830 S. Milton Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Koval

(a) RESIDENCE NO. 830 S. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John S. Koval

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Agnes Brocki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John S. Koval.

(Address) 830 S. Milton Ave.

15 Filed OCT 20 1921 H E Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1921, to Oct. 19, 1921, that I last saw alive on Oct 19, 1921, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. D. Ober, M. D.

, 19 (Address) 408 Park Pl Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D. Gamiano Crem. DATE OF BURIAL: Oct 21. 1921.

20 UNDERTAKER: M. F. Sadowski. ADDRESS: 705 S. Ann St

TION is very important. See instructions on back of certificates.

Rec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57896

CERTIFICATE OF DEATH.

D 57896

REGISTERED NO. 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Mueller

(a) RESIDENCE. NO. Baltimore Md ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17 yrs	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): School
(c) Name of employer: 000

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Bernard Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Augusta Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Mount Hope Records
(Address)

15 Filed OCT 20 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19. 192

17 I HEREBY CERTIFY, That I attended deceased from Feb 21st, 1920, to Oct. 19, 192, that I last saw her alive on Oct. 19, 192, and that death occurred on the date stated above, at 10.35 a. m.

The CAUSE OF DEATH* was as follows:

Gastritis — Complicated by Endocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Juvenile Psychosis (duration) 1 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 21 192[illegible]
20 UNDERTAKER: J. Herwig & Co	ADDRESS: 2008 Eutaw

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57897

64 D 57897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. 1716 Barclay ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Bosley

(a) RESIDENCE. No. 1716 Barclay ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ann Maria Foos

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Ruth----------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Charles L. Bosley
(Address) 317 E. Lafayette Avenue

15 FILED OCT 20 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1921, to Oct 18, 1921, that I last saw h alive on Oct 17, 1921, and that death occurred, on the date stated above, at 9.40A m.

The CAUSE OF DEATH* was as follows:

A Bosley

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Senility Arteria-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr Bevan and Wess, M. D.

10/19. 1921 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/21 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15714 D 57898

1-91 D 57898

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eula May Cyrus

(a) RESIDENCE. NO. 326 N. Colvin St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26th, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Born in Baltimore 12 months N. C

PARENTS

10 NAME OF FATHER John Cyrus

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Courtney Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed OCT 20 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-5 , 1921 , to 10-17 , 1921 , that I last saw h alive on 10-17 , 1921 , and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood culture + Widal.

(Signed) Horace G. Stewart, M. D.

10 17 , 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct-2 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back of certificates.

Ossinger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57899 D 57899

CERTIFICATE OF DEATH.

1 PLACE OF DEATH 160 miles off of Cape Henry X 79 REGISTERED NO. C

CITY OF BALTIMORE (No. Steamship Robin Gray St.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ernest Ossinger

(Residence in Baltimore: No. No residence in Baltimore St.; yrs., mos. ds.)
Last boarded at foot of Clinton St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 36 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chief Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): U.S.

9-BIRTHPLACE, (State or Country): Not known

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country): Not known

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (State or Country): Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Castle Tallot Station

(Address) Baltimore Md

15- OCT 20 1921 191.... Filed ROBT. J. KRAUTER Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D W Fridley M. D. (Coroner.)

Oct 20, 1921 (Address) 1504 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Seattle Washington DATE OF BURIAL, Oct 20 1921

20-UNDERTAKER H. W. Caulbaugh ADDRESS 1809 Ray Street

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57900

CERTIFICATE OF DEATH.

D 57900

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Argyle Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Adelaide Cordrey

(a) RESIDENCE. NO. 1530 Argyle Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of John H Cordrey Widowed 1855

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cambridge Maryland

PARENTS

10 NAME OF FATHER Rev. Benj. Penniston

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Clemmie Griffin

(Address) 633 Greenmount Ave.

OCT 20 1921

[illegible] S KRAUTER Registrar

Burial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th, 191 , to Oct 18th, 1921.

that I last saw her alive on Oct 18 , 1921.

and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Garrison Isaacs M. D.

10/19 1921 (Address) 701 Mystic Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Park

DATE OF BURIAL 21 Oct 31 1921

20 UNDERTAKER Samuel Kemsley

ADDRESS 518 N Eutaw St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Morris R. Knight

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57901

CERTIFICATE OF DEATH.

150 D 57901

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Woodley ST.: 16 WARD)

2-FULL NAME Morris Poyton Knight

(a) RESIDENCE. NO. 1119 Woodley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William C Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Beulah Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant William C Knight

(Address) 1119 Woodley

15 F[illegible] OCT 20 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1921, to Oct 19, 1921, that I last saw h[illegible] alive on Oct 18, 1921, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Congestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) Chas A Fetterhoff, M. D.

, 19 (Address) 1807 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 20 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Eutaw Pl

Burial Permit Issued

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 57902 — 79 D 57902

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No 1825 N. Charles ST. — WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Blanche N. Hamill

(Residence in Baltimore: No. 1825 N. Charles St.: 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widowed

6 DATE OF BIRTH: April (Month) 16 (Day), 1852 (Year)

7 AGE: 69 yrs. 6 mos. 2 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Phila Pa

PARENTS

10 NAME OF FATHER: Benjamin F. Grove

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Emily Pfeil

13 BIRTHPLACE OF MOTHER (State or country): Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Pauline Hekseg

(Address) 833 Park Ave

15 Filed OCT 20 1921 BOSLEY & KRAUTER Burial Permit Record

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 18 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct-2, 1921, to Oct 18 1921, that I saw her alive on Oct. 17, 1921, and that death occurred, on the date stated above, at 3 18 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) not Known yrs. ..... mos. ..... ds

Contributory (SECONDARY) Coronary Thrombosis

(Duration) ..... yrs. ..... mo. 16 ds.

(Signed) Herman Seidel M. D.

Oct. 19. 1921 (Address) 2404 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Green Mount — DATE OF BURIAL: Oct 20 1921

20 UNDERTAKER: John Mitchell — ADDRESS: 1201 W. Fayette St.

---

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57903

CERTIFICATE OF DEATH.

91

D 57903

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Church Home ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura A. Lawrence

(a) RESIDENCE. No. Church Home N. Broadway. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther L. Lawrence

6 DATE OF BIRTH (month, day, and year) May 10, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER David K. Vaughorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Betsy Farrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant Geo E. Lawrence

(Address) Bethlehem Pa

15 OCT 20 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/1921

17

I HEREBY CERTIFY, That I attended deceased from 10/17/1921, to 10/20/1921,

that I last saw h.e alive on 10/19/1921,

and that death occurred, on the date stated above, at 3 20 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Pulmonary edema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency & failure

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) A B Steele, M. D.

10/20/1921 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Cem - Oct 21	1921

20 UNDERTAKER John O. Littlehell ADDRESS 1201 W. Fayette St

TION is very important. See instructions on back of certificates.

D 57904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167

D 57904

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. Franklin Square Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Clarence Rice

(Residence in Baltimore: No. 1150 N Calhoun St; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Sgl

6-DATE OF BIRTH Oct (Month) 12 (Day), 1919 (Year)

7-AGE, 2 yrs. mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): @ home

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo. Rice

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Ada Mclemore

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Rice

(Address) 1150 Calhoun St

15- Filed OCT 20 1921, 191. ROBERT J. KRAUSE Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

3-3 Burns over Greater part of body by falling into Hot water Accidental

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

(Signed) James M Reuben M. D. (Coroner.)

Oct 20, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1150 N Calhoun St

Former or usual residence 1150 N Calhoun

19-PLACE OF BURIAL OR REMOVAL, Laurel — DATE OF BURIAL, Oct 21, 19 21

20-UNDERTAKER Geo H Holland — ADDRESS 1631 Druid Hill Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57905

D 57905

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 509 E 36 St ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis A Johnson

(a) RESIDENCE. NO. 509 E 36 St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs mos ds How long in U. S., if of foreign birth? 55 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Johnson

6 DATE OF BIRTH (month, day, and year): Nov 29-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68 yr	11	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): — 014

(c) Name of employer: John G. Moore

9 BIRTHPLACE (city or town) (State or country): Bermuda Island

PARENTS

10 NAME OF FATHER: John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bermuda Island

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bermuda Island

14 Informant: Clara Johnson
(Address) 509 E 36th St

15 Filed OCT 20 1921 19 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11 1921, to Oct 18 1921, that I last saw h alive on Oct 18 1921, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. [illegible] M. D.

10/19/1921 (Address) 401 E 35th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 21 1921
20 UNDERTAKER	ADDRESS
H. C. Windefeld	914 Gunmt Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1800 Blks.

Dept of Lavinia Mason. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57906

15 ✓ D 57906

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Chilia ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — mason

(a) RESIDENCE NO. 821 Chilia ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/18/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) 400

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) maryland

PARENTS

10 NAME OF FATHER Archie mason Calvert Co

11 BIRTHPLACE OF FATHER (city or town)
(State or country) maryland.

12 MAIDEN NAME OF MOTHER Sonia Parker Calvert Co

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) maryland

14 Informant Lorna mason
(Address) 821 Chilia St

15 OCT 20 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/18, 1921, to 10/19, 1921.

that I last saw him alive on 10/18, 1921.

and that death occurred, on the date stated above, at 1a, m.

The CAUSE OF DEATH* was as follows:

Premature 7 mo
duration - Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Maternal cause —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David Franklin M. D.

10/19 1921 (Address) 1222 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	ADDRESS
20 UNDERTAKER Commissioner Health.	OCT 1 1921

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates.

TION is very important.

6

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 57907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57907

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2604 Guilford Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice F. Dean

(a) RESIDENCE. No. 2604 Guilford Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
(or) WIFE of George A. Dean

6 DATE OF BIRTH (month, day, and year) July 31. 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Joseph J. ONeill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Annie W. Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: George A. Dean
(Address): 2604 Guilford Ave

15 Filed: Robert P. Harrison, Registrar
01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19. 1921 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to Oct 19, 1921, that I last saw h[illegible] alive on Oct 19, 1921, and that death occurred, on the date stated above, at 3:00A m.

The CAUSE OF DEATH* was as follows:

Acute parenchymatous Nephritis (duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Strkett M. D.

10/20 1921 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 21-21 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	434 N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57908

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE, No. St Agnes Hospital ST. 17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rosa M. Webb.

(a) RESIDENCE No. The Cambridge Apt. ST. St Paul + 31st St. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (Write the word) Widow

5a If married, widowed, or divorced (or) WIFE of Frank W. Webb

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Not any.
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Field

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. J. Caldwell
(Address) 3910 Greenhill Rd

15 Filed 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1921, to 10-20, 1921, that I last saw her alive on 10-20, 1921, and that death occurred, on the date stated above, at 8½ a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Ascending Colon - Cerebral Embolus.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes - Date of Apr. 1921

Was there an autopsy? No - Opinion

What test confirmed diagnosis?

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cem. DATE OF BURIAL 10/22 1921

20 UNDERTAKER John F. Gallagher & Sons ADDRESS 1315 Eutaw Pl

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57909 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57909

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 726 W Mulberry (St.) 17 (Ward)

2-FULL NAME Josephine Upshur

(a) RESIDENCE. No. 726 W Mulberry St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Upshur

6 DATE OF BIRTH (month, day, and year) June 1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) King & Queen Co. Virginia

PARENTS

10 NAME OF FATHER Henry Garnett

11 BIRTHPLACE OF FATHER (city or town) King & Queen Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hattie V. Taylor (Address) 147 N. Carey Ste.

15 Filed 2 01921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1921, to Oct 19, 1921, that I last saw h[illegible] alive on Oct 18, 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R Cooley, M. D.

, 19 (Address) 723 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bowlers Mill. Essex Co. Va	Oct. 21 1921
20 UNDERTAKER Katie R. Williams	ADDRESS 1114 W. Saratoga St.

TION is very important. See instructions on back of certificates.

D 57910

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120

D 57910

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No 1738 Hanover St St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anthony P. Cadden

(Residence in Baltimore: No. 1738 Hanover St St.; 59 yrs. 9 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: December 31, 1862 (Month) (Day) (Year)

7 AGE: 59 yrs. 9 mos. 17 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): on Steamships

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Cadden

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna Hughes

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Cadden
(Address) 1738 Hanover St

15. Robert P. Harrison,
Filed ..., 191...
T 2 01921 Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 17, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Oct 17 1921, that I saw him alive on Oct 17, 1921, and that death occurred, on the date stated above, at 10 20 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 1 mos. 2 ds

Contributory (SECONDARY) Uraemic Coma

(Duration) ... yrs. ... mos. 4 ds.

(Signed) Thos F. Stevens M.D. M. D.
Oct 20, 1921 (Address) 2878 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Oct 21, 1921

20 UNDERTAKER: Margaret G. Flynn ADDRESS: 1411 Eutaw

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 57911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89

D 57911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 Rock ST. 18 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave Froehlich

(a) RESIDENCE No. 308 Rock ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 43 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Froehlich

6 DATE OF BIRTH (month, day, and year) Feb 12/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Gustave Froehlich

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Elise Meyers

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Switzerland

14 Informant Annie Froehlich
(Address) 308 Rock St

15 Filed ..., 19 ... Registrar

Robert P. Harrison,
Burial Permit Clerk.

2 01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16 ..., 1921 ..., to Oct 18 ..., 1921 ..., that I last saw h alive on Oct 18 ..., 1921 ..., and that death occurred, on the date stated above, at 7 50 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis
Senility

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of ...

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robt. J. Murray M. D.

10-19-1921 (Address) 516 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Oct 4 1921

20 UNDERTAKER ... ADDRESS Mc Cabe 502 E Baltimore

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57912

D 57912

CERTIFICATE OF DEATH

120

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. 13 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Berenbomp.

(a) RESIDENCE. NO. 2814 Evergreen Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

11 Informant Bay View Hospital (Address) Baltimore, Md.

15 Filed Robert P. Harrison, 19 Registrar

01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1921 to Oct. 19, 1921 that I last saw h in alive on Oct. 19, 1921 and that death occurred, on the date stated above, at 10 00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Goldsmith M. D.

10/24 1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Whaleyville, Md

DATE OF BURIAL Oct 23, 1921

20 UNDERTAKER Wm Coats.

ADDRESS 502 E. North

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57913 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57913

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 W Lafayette Av ST.: 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund Francis Beall

(a) RESIDENCE. No. 1811 W Lafayette Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Louise E. Beall

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER Thomas Beall

11 BIRTHPLACE OF FATHER (city or town) Prince George Co (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Birkmyre

13 BIRTHPLACE OF MOTHER (city or town) Prince George Co (State or country) Md

14 Informant Mrs. Louise E. Beall

(Address) 1811 W Lafayette Av

15 Filed 19 Registrar

201921 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19. 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to date of death 1921, that I last saw him alive on Oct. 19. 1921, and that death occurred, on the date stated above, at 1.15 P.M. The CAUSE OF DEATH* was as follows:

Duc to an interstitial hyperplasia of an indefinite duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) Dunlap Van Dorn, M. D.

, 19 (Address) 814 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Oct 21 1921
20 UNDERTAKER George D. Frech & Son	ADDRESS 1000 N Eutaw St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57914

CERTIFICATE OF DEATH.

37 D 57914

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 304 Augusta St.: 20 (WARD)

2-FULL NAME. Henry H. J Broessel

(a) RESIDENCE. No. 304 Augusta ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov 24-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 966

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henr Broessel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ed Broessel

(Address) 304 Augusta Ave

15 Filed OCT 21 1921 ROBERT A KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1921, to Oct 19, 1921, that I last saw h alive on Oct 19, 1921, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia 5032

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) H. A Krull, M. D.

Oct 20, 1921 (Address) 420 Fairfax

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 21 21

UNDERTAKER: Harry H. Witzke — ADDRESS: 531 W Lombard

CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly due to liver.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57915

CERTIFICATE OF DEATH.

28 D 57915

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N. Bouldin ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Eggleston

(a) RESIDENCE. No. 2852 Woodbrook Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada M. Eggleston

6 DATE OF BIRTH (month, day, and year) Jany 27, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Zentgraf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Foelix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Ada M. Eggleston
(Address) 2852 Woodbrook Ave

15 FILED OCT 21 1921 ROBERT A. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany. 13. 1913. to Oct. 18. 1921.
that I last saw her alive on Oct. 18, 1921.
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination.

(Signed) Maurice E. Shamm, M. D.

10/19. 1921 (Address) 3300 N. North.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 21 1921

20 UNDERTAKER Harry A. Witzke ADDRESS 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of death TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57916

CERTIFICATE OF DEATH.

79 D 57916

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., [redacted] WARD)

2-FULL NAME Jim. Pender

(a) RESIDENCE NO. US.PHSHosp. #56 Balto, Md. ST., [redacted] WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
over unknown	---	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) unknown 087

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Balto, Md.

15 Filed OCT 21 1921 ROBERT A KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to Oct 17, 1921, that I last saw him alive on Oct 17, 1921, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Infarct of lung.

--- (duration) --- yrs. --- mos --- ds.

CONTRIBUTORY (Secondary) Myocarditis chronic.

--- (duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings.

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

10/19/21 (Address) US PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Oct 21, 1921

20 UNDERTAKER Sol Lusiston & Bro — ADDRESS 112 E. Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

(Ida Erlich)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57917

CERTIFICATE OF DEATH.

170

D 57917

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ida Erlich

(Residence in Baltimore: No. 216 S Pats PK ave. St.; 14 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1893 (Year)

7-AGE, 28 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Michael Miller

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Balto St.

15- FILED OCT 21 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Oct 20 1921, that I saw h er alive on Oct 20, 1921, and that death occurred, on the date stated above, at 12 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Julius Holtzman M. D.

Oct 20, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ## yrs. mos. 14 da. In the State 14 yrs. mos. da.

Where was disease contracted, if not at place of death? ?

Former or usual residence 216 S. Pats. PK. Ave.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cemetery — DATE OF BURIAL, Oct. 21, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Balto

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57918

CERTIFICATE OF DEATH.

81 D 57918

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 Bartlett. Ave. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hartman. A. Miller

(a) RESIDENCE NO. 653 Bartlett. Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred About 65 mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of The late Martha.A.Miller

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 82		-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Drayman 023

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Mary. McKeowne

(Address) 653 Bartlett. Ave.

15 Filed OCT 21 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct.-20-1921

17 I HEREBY CERTIFY, That I attended deceased from 10-11, 1921, to 10-20, 1921, that I last saw h[illegible] alive on 10-20, 1921, and that death occurred, on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Senility

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Weiss, M. D.

10/21 1921 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct. 24/21

20 UNDERTAKER Henry Hoeltzlow ADDRESS 130 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 57919

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 413 N Mount (St.) (Ward) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Barber

(a) RESIDENCE. No. 413 N. Mount St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Barber

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mfr

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Philip Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Morgante Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co.

14 Informant (Address): Frank Barber 413 N. Mount St.

15 Filed: OCT 21 1921 19 [illegible] Registrar

Burial Permit Clerk

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to Oct 18, 1921, that I last saw h[illegible] alive on Oct 17, 1921, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

At Side Brain

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Nephritis (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

Oct 18, 1921 (Address) 809 Tyrrell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 21 1921
20 UNDERTAKER: Sam'l W. Chase Son	ADDRESS: 1660 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57920 — 109 — D 57920 — REGISTERED NO.

1-PLACE OF DEATH Church Home and Infirmary

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 136 N. Broadway ST.: ? WARD)

2-FULL NAME Mr. George Gebelein Jr

(a) RESIDENCE. NO. 828 N. Chester St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of Annie Gebelein

6 DATE OF BIRTH (month, day, and year) Nov. 10th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pork Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md,

PARENTS

10 NAME OF FATHER George Gebelein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora M. Minnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Gebelein Jr (Address) 828 N. Chester St

15 Filed OCT 21 1921 ROBERT I. FRAZIER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1921, to Oct. 19, 1921, that I last saw h[illegible] alive on October 19, 1921, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus.

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bilateral Hernia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 9, 1921.

Was there an autopsy? Yes

What test confirmed diagnosis? Embolus in pulmonary artery

(Signed) W. D. Noble, M. D.

, 19 (Address) Church Home and Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cmetery	Oct 24th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

150602
~~D 57921~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137 D 57921

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Belle Johnson.

(a) RESIDENCE NO. 1117 E Monument St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Mrs. Jane Smoot (mother) 815 Small St. Balto. Md.

6 DATE OF BIRTH (month, day, and year) March 4, 1897

7 AGE: Years 24 | Months 1 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework. 070

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Born in Balt. City

PARENTS

10 NAME OF FATHER: Calvin Smoot.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Davis.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: JOHNS HOPKINS HOSPITAL. Records
(Address)

15 OCT 21 1921 ROBERT A. CULVER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Oct 19, 1921, that I last saw her alive on Oct 19, 1921, and that death occurred, on the date stated above, at 10 a.m. P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection.
c Broad Ligament Abscess.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) H. Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery | DATE OF BURIAL: Oct 19 1921

20 UNDERTAKER: Mrs Robert A Elliott | ADDRESS 1725 Ashland Av

TION is very important. See instructions on back of certificates.

Lipscomb

D 57922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N Fremont Av ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo R. Lipscomb

(a) RESIDENCE. No. 426 N Fremont Av ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 28-1920

7 AGE: Years — Months 9 — Days 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gatts Ind

PARENTS

10 NAME OF FATHER George Lipscomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Sadler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant George Lipscomb

(Address) 426 N Fremont Av

15 OCT 21 1921 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 18th, 1921, to Oct 18th, 1921, that I last saw him alive on Oct 18, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Marasmus 0 Yrs

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? only seen child once

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J Hmanges M. D.

. 19 (Address) 1008 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 21, 1921

20 UNDERTAKER — ADDRESS

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will he sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly due to gastro Enteritis

D 57923

HEALTH DEPARTMENT—CITY OF BALTIMORE D 57923

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J. Ried.

(Residence in Baltimore: No. 1748 Jackson St. St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, October 21st. 1895., 1 .....
(Month) (Day) (Year)

7-AGE, 25 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Garbage cart No 23
(b) General nature of industry, business, or establishment in which employed (or employer)..... driver Balto. City

9-BIRTHPLACE, (State or Country), Cleveland Ohio.

PARENTS.

10-NAME OF FATHER, Daniel Ried.

11-BIRTHPLACE OF FATHER (State or Country). Cleveland, Ohio

12-MAIDEN NAME OF MOTHER Mary I. --------

13-BIRTHPLACE OF MOTHER (State or Country), Cleveland, Ohio.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Ried. (wife)

(Address) 1748 Jackson St.

15-

Filed OCT 21 1921 191.....

ROBERT J. KRAUTER
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) & Inquest... find that said deceased came to... his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage due to a pistol shot wound in the left chest.
Homicide.

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) Otto T. C. Reinhardt M. D.
(Coroner)

Oct 20..., 191 21 (Address) 1517 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
in front of 24 Hazel St. Curtis Bay.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Oct 21., 19..

20-UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 57924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1821

D 57924

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital 25 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Allen

(Residence in Baltimore: No. 24 Hazel St. Curtis Bay. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, November 7th. 1867, 1
(Month) (Day) (Year)

7-AGE, 53 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Acid boss 086
(b) General nature of industry, business, or establishment in which employed (or employer): Baystar Guano Co.

9-BIRTHPLACE, (State or Country), Harford Co. Md

PARENTS.

10-NAME OF FATHER, William Allen.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Isabelle McElroy.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Allen (wife)

(Address) 24 Hazel St. Curtis Bay.

15- Filed OCT 21 1921 191 ROBERT J. KRAUTER Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18th. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage & shock, due to a pistol shot wound in the left side of his neck. Homicide.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Pennsdorf M. D.
(Coroner)

Oct. 20., 1921 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 10 min. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....in front of 24 Hazel St. Curtis Bay

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	Oct 21, 19..
20-UNDERTAKER Margaret E. Flynn	ADDRESS 422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of occupation important. See instructions on back of certificate.

Piornack

D 57925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1530 Bond St. ST. 3 WARD) REGISTERED NO. C 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME H Mary Piornack

(Residence in Baltimore: No. 1530 Bond St.) St.; yrs. 58 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 29 (Day), 1863 (Year)

7-AGE. 58 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Martin Metzger

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kirschman

(Address) 1334 E Fort Ave

15- Filed OCT 21 1921, 191.... ROBERT A KRAUTER Registrar Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxia by Illuminating Gas

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) C Henry Young M. D. (Coroner.)

Oct 21, 1921. (Address) 1002 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Oct 24 1921
20-UNDERTAKER	**ADDRESS**
Mc Goverty & Flynn	1422 Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57926

D 57926

CERTIFICATE OF DEATH.

REGISTERED NO. 102

1-PLACE OF DEATH 1521 N. Chapple St

CITY OF BALTIMORE: (No. 1521 N. Chapple St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred F. Kraft

(a) RESIDENCE. NO. 1521 N. Chapple St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 11 mos. 30 ds. How long in U. S., if of foreign birth? 16 yrs. 11 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
16	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Robert Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City Md

12 MAIDEN NAME OF MOTHER Florence E. Burlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md

14 Informant Robert Kraft
(Address) 1521 N. Chapple St.

15 Filed OCT 21 1921 ROBERT J. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16 1921, to Oct. 20 1921, that I last saw h[illegible] alive on Oct. 20 1921, and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(Duration) yrs. mos. 7 ds.

Haemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William Krause, M. D.

(Address) 1407 W Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Schwartz Cem. DATE OF BURIAL Oct 24 1921

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Perforating gastric ulcer. Not malignant

Spec.—6-9-19—H. P. Co.—1000 Blks.

Richie

HEALTH DEPARTMENT—CITY OF BALTIMORE

57927 108 D 57927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. E. Monument ST.; 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Reuhe

(a) RESIDENCE. NO. 817 N. Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? 16 yrs. 11 mos 30 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Grief Balto.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry W. Reiche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md –

12 MAIDEN NAME OF MOTHER Bertha Getus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bertha Reiche (Address) 817 N. Madeira St–

15 OCT 21 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1921, 19.., to Oct 20, 1921, that I last saw her alive on Oct 20, 1921, and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute appendicitis ruptured

(duration) yrs. mos. 5+ ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 10/18/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Ernest Edlavitch, M. D.

10/20, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Oct 24 1921
20 UNDERTAKER Philip Hering	ADDRESS 2016 Orleans St–

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57928

CERTIFICATE OF DEATH.

79 D 57928

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Samuel Harper (35 Bank St. Princeton, N. J.)

(a) RESIDENCE. No. 1031 N. Calvert St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ~~Mary Eggleston~~ Miriam Eccleston.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record
(Address) Union Memorial Hosp.

15 OCT 21 1921 ROBERT S. BRANNER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1921, to Oct. 20, 1921, that I last saw him alive on Oct. 20, 1921, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-renal syndrome.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George E. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Oct 22 1921
20 UNDERTAKER Henry J. Jenkins & Sons Co	ADDRESS McCulloh & Orchard

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Professor at Princeton but always maintained home at 1031 Calvert St.

4/8/32 Correction made by me by order of Dr. Williams, Deceased. Correspondence of file in this office.

H. A. Moore
Chief Statistical Clerk

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57929

CERTIFICATE OF DEATH.

40 D 57929

1-PLACE OF DEATH Church Home + Infirmary Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 176 Broadway ST.: [illegible] WARD)

2-FULL NAME Mrs. Louis Porter

(a) RESIDENCE. NO. 34 E. Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Porter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Porter

(Address) 1411 E. Balto.

15 Filed OCT 21 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 19 21, to Oct 21, 19 21, that I last saw him alive on Oct 20, 19 21, and that death occurred, on the date stated above, at 9 40 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach -

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) None known.

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? Yes Date of Oct 18 '21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Keith G. Rice, M. D.

19 (Address) Church Home + Inf. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Russdale	10-21 1921

20 UNDERTAKER Fact Bros, 411 E. Balto ADDRESS

Instructions on back of certificates. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

157321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57930

CERTIFICATE OF DEATH.

X 74

D 57930

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Glenn Ammon. Indiana.

(a) RESIDENCE. No. 11 Randall Ave. Evansville, WARD. Evansville Ind.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

6 If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ Grover H. Ammon (father).

6 DATE OF BIRTH (month, day, and year) July 2, -?-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. H.

PARENTS

10 NAME OF FATHER Grover H. Ammon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. H.

12 MAIDEN NAME OF MOTHER Lena Farrell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. H.

14 Informant JOHNS HOPKINS HOSPITAL.

(Address) Baltimore

15 Filed OCT 22 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1921 to Oct 19, 1921 that I last saw h[illegible] alive on Oct 19 1921 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia of Cerebellum.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Edema from Operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ambromon.

Did an operation precede death? Yes Date of 10/19/21

Was there an autopsy? Yes.

What test confirmed diagnosis? T

(Signed) Dr C. B. Coleman, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clayton New York	Oct 21st 1921
20 UNDERTAKER	ADDRESS
Geo M. Frick & Son	811 N Ave

TION is very important. See instructions on back of certificates.

D 57931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 57931

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 409 Regester ST. V WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Peter Burch

(Residence in Baltimore: No. 409 Regester St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Oct 20, 1931 (Month) (Day) (Year)

7-AGE: ...yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or ...min.? 8 hrs

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Henry Burch

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Annie Brachi

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Burch 409 Regester St.

(Address) Baltimore Md

15- Filed OCT 21 1931, 191... ROBERT J. KRANTZ Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: October 20, 1931 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

(Signed) Henry Epps Jr M. D. (Coroner)

Oct 21 31, 191... (Address) 1800 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: St. Stanislaus Cem. DATE OF BURIAL: Oct 21, 19 31

20-UNDERTAKER: M F Sadowski ADDRESS: 905 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57932

CERTIFICATE OF DEATH.

D 57932

REGISTERED NO. 78 D 57932

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Municipal Tuberculosis Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Davis (Daniel) Byrd

(a) RESIDENCE. No. 13 W. York st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ester Bibbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 OCT 21 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to Oct. 18, 1921, that I last saw him alive on Oct. 18, 1921, and that death occurred, on the date stated above, at 8.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L. Dadaglian M. D.

10-19-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS OCT 21 1921

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57933

D 57933

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL St.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Baff Harlow

(a) RESIDENCE. No. 119 Hawthorn Rd Roland Park St., 27 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 33 yrs. 2 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Earl Harlow

6 DATE OF BIRTH (month, day, and year) Aug 20-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Cambridge Mass

PARENTS

10 NAME OF FATHER: Geo. N. Baff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret E. Herrmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): JOHNS HOPKINS HOSPITAL Friends

15 OCT 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to Oct - 20, 1921, that I last saw h[illegible] alive on Oct 20, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Anemia Thrombosis (Saturne) Chr. mal Tai dis.
(duration) yrs. mos. d.

18 Where was disease contracted if not at place of death? 10-1-21

Did an operation precede death? yes Date of 10-16-21

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) E. W. Brughs, M. D.

(Address) J.W.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boston Mass

DATE OF BURIAL: Oct 23 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Manager)

ADDRESS: [illegible] W. NORTH AVE.

[illegible] LARROS

IMPORTANT—Certificate may be properly examined. Fair Name of Deceased TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57934

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 57934

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Bolton ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Allen

(a) RESIDENCE. NO. 1801 Bolton ST., 14 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? 67 yrs. 2 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Brown M. Allen

6 DATE OF BIRTH (month, day, and year) Aug 13-1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Fincastle Va

PARENTS

10 NAME OF FATHER James M. Figgatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fincastle Va

12 MAIDEN NAME OF MOTHER Susan Wyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fincastle Va

14 Informant Mr W. R. Wilmer

(Address) 1005 St Paul St

15 OCT 21 1921 ROBERT A. KRAUTER Registrar

16 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1920, to Oct 20, 1921, that I last saw h[illegible] alive on Oct 20, 1921, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble.

(Mitral Insufficiency).- Myocarditis

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Owings, M. D.

1920, 19-1 (Address) 1733 Lenderman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Oct-22-1921.

20 UNDERTAKER: [illegible] MOWER COMPANY — ADDRESS: 108 W. NORTH AVE

[illegible] E. WOODEN, Secretary

CAUSE OF DEATH to be plain terms, so that a TION is very important. See instructions on b

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 57935

CERTIFICATE OF DEATH

8 D 57935

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No 217 N. Gilmor ST 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Walter B Schmidt

(Residence in Baltimore: No. 217 N Gilmor St.: 40 yrs. 6 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 1, 1881 (Month) (Day) (Year)

7 AGE 40 yrs. 6 mos. 18 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Shipper (Biscuit)

9 BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry L. Schmidt

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mathilda Bobeck

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas B. Schmidt

(Address) Roslyn Apts (Walbrook)

15. Filed OCT 21 1921 ROBERT S. BRUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 19, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1921, to, Oct 19 1921, that I saw h[illegible] alive on Oct 19, 1921, and that death occurred, on the date stated above, at 5.50 P m. The CAUSE OF DEATH* was as follows:

Cardiac Syncope

(Duration) yrs. mos. 1 ds

Contributory (SECONDARY) Bronchitis.

(Duration) yrs. 2 mos. ds.

(Signed) A. Holland Keech M. D.

Oct 20, 1921 (Address) 219 N. Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Loudon Park Cem. | DATE OF BURIAL Oct 21st, 1921

20 UNDERTAKER Joseph B Cook | ADDRESS 1003 N. Balto St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Refer to further history

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Blks.

D 57936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57936

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S. Castle ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph King

(a) RESIDENCE NO. 225 S. Castle ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary King

6 DATE OF BIRTH (month, day, and year): July - 1854

7 AGE — Years: 67 — Months: 3 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Huckster

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Patrick King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary King (Address) 225 S. Castle St.

15 Robert T. Harrison, Registrar

T 21 1921 .19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18th 1921

17

I HEREBY CERTIFY, That I attended deceased from April 3 ..., 1921 ..., to Oct. 19 ..., 1921.

that I last saw him alive on Sept. 18 ..., 1921

and that death occurred, on the date stated above, at 10 ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Laboratory.

(Signed) Geo. Keller M. D.

Oct. 19th (Address) 1437 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral Cemetery — DATE OF BURIAL: 10-22 1921

20 UNDERTAKER: J. A. Moran — ADDRESS 3000 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57937

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2721 E Jeffers ST.; 6 WARD)

2-FULL NAME Albert S Gordon

(a) RESIDENCE. No. 2721 E. Jefferson ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose H. Gordon.

6 DATE OF BIRTH (month, day, and year): Jan 15 1875

7 AGE: Years 46 Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer): — D61

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Geo. Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston Mass.

12 MAIDEN NAME OF MOTHER: Catherine Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Rose Gordon 2721 E. Jefferson h

15 Filed ..... 19 ..... Registrar

Robert P Harrison, Burial Permit Clerk.

OCT 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 19 24

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 19 24, to Oct 18, 19 24, that I last saw h alive on Oct 18, 19 24, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis.

(duration) X yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. F. Meyer Jr. M. D.

10/24 19 24 (Address) 1638 E Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	10-22 1924
20 UNDERTAKER	ADDRESS
J. A. Moran	3000 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. FAILURE to GIVE FULL INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57938

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 E. Hull ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles D. H. Payne

(a) RESIDENCE NO. 1412 E Hull ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sophia Payne

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipbuilder

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1/16

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sophia Payne

(Address) 1412 E Hull St

15 Filed ....., 19.... Registrar

T 21 1921 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1921, to Oct 20, 1921, that I last saw him alive on Oct 20, 1921, and that death occurred, on the date stated above, at 8 — 1 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nefritis

about 3 yrs. 0 mos 0 ds.

(duration)

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) Chas. T. Seabury, M. D.

10/21 1921 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill.	Oct 22nd.

20 UNDERTAKER Wm Cook ADDRESS 502 E. Hamburg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 57939 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57939

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 186 N. Fort Ave. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bente

(a) RESIDENCE. NO. 186 N. Fort Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. - mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Bente

6 DATE OF BIRTH (month, day, and year) Oct 9, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Martin Carill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Ellen Donovan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Henry Bente (Address) 186 N. Fort Ave

15 Filed OCT 21 1921 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Oct 19, 1921, that I last saw h alive on Oct 19, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) Months yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. E. H. Campbell M. D.

Oct 21 1921 (Address) 1644 Hanover st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Oct. 22 1921
20 UNDERTAKER Margaret D. Flynn	ADDRESS 1422 Light st

TION is very important. See instructions on back of certificates.

Heeke

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57940

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO. 4497

CITY OF BALTIMORE: (No. South Balto Hospital ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Heeke

(a) RESIDENCE. NO. 1314 S Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Heeke

6 DATE OF BIRTH (month, day, and year) 8 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Battery Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Richmond Virginia

PARENTS

10 NAME OF FATHER Henry Heeke

11 BIRTHPLACE OF FATHER (City or town) (State or country) ~~Ft~~ Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jesse Heeke

(Address) 1314 S Charles st.

15 Filed 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20 1921 to Oct 21 1921, that I last saw him alive on Oct 21 1921, and that death occurred, on the date stated above, at 12.25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Pokorny, M. D.

, 19 (Address) South Balto. Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va.	Oct. 21 1921
20 UNDERTAKER	ADDRESS
John J Tobey & Sons	1318 Eight

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57941

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 S Calhoun ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma A Trieber (1

(Residence in Baltimore: No. 405 S Calhoun St.; 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept 30, 1851 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
70 yrs. 0 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Peter H Zittle

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine Hutzel

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C A Trieber

(Address) 405 S Calhoun st

15-

Filed Oct 21 1921, Robert P. Harrison, Registrar.

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1921, to Oct 21 1921, that I saw h[illegible] alive on Oct 20 1921, and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Fred O Jewett M. D.

Oct 21, 1921 (Address) 2516 Barnes

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Oct 24, 1921
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 N Bond St

Spec.—1-10-21—M&T—1500 Bks.

D 57942 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

120 D 57942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frederick Wiessner

(a) RESIDENCE NO. US PHS Hosp. #56 Balto, Md. ST., [redacted] WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work moulder 47

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar

(Address) US PHS Hosp. #56 Balto, Md.

15 Oct 21 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 19 21 to Oct 19, 19 21.

that I last saw him alive on October, 19, 19 21.

and that death occurred, on the date stated above, at 3'25 A.M.

The CAUSE OF DEATH* was as follows:

Valvular disease Chronic cardiac) mitral regurgitation , broken compensation.

Sept. 23,/21 (duration) — yrs. — mos ds.

CONTRIBUTORY (Secondary) Nephritis chronic parenchymatous.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R Payne M. D.

10/19 1921 (Address) Senior Surgeon (R) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Oct 24, 21

20 UNDERTAKER Jos Grimm & Bro — ADDRESS 1127 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57943 HEALTH DEPARTMENT—CITY OF BALTIMORE 80 D 57943

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Ward to Mercy Hosp from Court House

CITY OF BALTIMORE (No. ~~1720 N Broadway~~ ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellwood M Wellener

(Residence in Baltimore: No. 1720 N Broadway St.: 54 yrs., 8 mos. 5 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 15 (Day), 1867 (Year)

7-AGE, 54 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk in Co
(b) General nature of industry, business, or establishment in which employed (or employer): Court House

PARENTS.

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, John B Wellener

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Susan Alberger

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie J Wellener

(Address) 1720 N Broadway

15- Filed ....., 191.... Robert P Harrison, Registrar. Deputy Health Clerk.

21 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Instantaneous (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Put Him

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 21, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct 22 1921
20-UNDERTAKER W M Tucknor & Son	ADDRESS Balto Md

D 57944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57944

CERTIFICATE OF DEATH.

159

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2711 Elsinore Ave ST.) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. S. Throop,

(Residence in Baltimore: No. 2711 Elsinore Ave. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	married

6-DATE OF BIRTH. April 14, 1848
(Month) (Day) (Year)

7-AGE. 73 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Ills. Coal Co.

9-BIRTHPLACE, (State or Country), Kentucky

PARENTS.

10-NAME OF FATHER, Joshua V. Throop

11-BIRTHPLACE OF FATHER (State or Country). Kentucky

12-MAIDEN NAME OF MOTHER Eliza Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Throop

(Address) 2711 Elsinore Ave.

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

Oct 21 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide (Poisoning by Lead)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Oct. 21 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Evansville Ind.	Oct. 22, 1921
20-UNDERTAKER	ADDRESS
H. T. Eckener & Sons	[illegible] Elsinore Ave

R.C. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57945

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 S Thirteenth ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Pazoureks

(a) RESIDENCE. NO. 315 S. Thirteenth ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Pazoureks

6 DATE OF BIRTH (month, day, and year) Unknown 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Volek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Peter Pazoureks 315 S Thirteenth St.

Filed OCT 22 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1921, to Oct 20th, 1921, that I last saw her alive on Oct. 18th, 1921, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows: due to Chronic Valvular Heart Disease.

(duration) 7 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. Lyden Wells, M. D.

19 (Address) Stemmers Run Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rodeemer	Oct 24 1921
20 UNDERTAKER	ADDRESS
Frank Ecker & Son	1806 Orleans

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57946

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Port ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Svoboda

(a) RESIDENCE. No. 203 N. Port ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Joseph Svoboda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mamie Kupka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph Svoboda

(Address) 203 N. Port Ave.

15 Filed OCT 22 1921, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Oct 20, 1921, that I last saw h e alive on Oct 20, 19, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Colitis

(duration) 4 yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Nursery

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) V. Murphy, M. D.

10-20-21 Address 20 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 22 1921
20 UNDERTAKER Frank Brockdorf	ADDRESS 1916 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 57947

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N. Duncan ST.: 8 WARD)

2-FULL NAME Katherine Louise Patterson

(a) RESIDENCE. NO. 1812 N. Duncan ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 13 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Roland Franklin Patterson

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Edna B Mc Namara.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Roman Patterson
(Address) 1812 N Duncan st

15 Filed OCT 22 1921 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from October 18, 1921, to Oct 20, 1921, that I last saw her alive on October 20, 1921, and that death occurred, on the date stated above, at 8 50 P. m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

18 hr.
(duration) yr. mos. ds.

CONTRIBUTORY (Secondary) Ileo colitis
(duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stools.

(Signed) Daniel Miller, M. D.

, 19 (Address) 1506 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Oct 22 1921
20 UNDERTAKER Ernest Crockett	ADDRESS 1906 Bolton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57948

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Wallace

(a) RESIDENCE. No. 421 North Conway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-9-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER George Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records.
(Address)

15 Filed 19 Registrar
Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-17, 1921, to 10-21, 1921, that I last saw him alive on 10-20, 1921, and that death occurred, on the date stated above, at 2.40 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Tubercle bacilli in C.S.F.

(Signed) Horace G. Stewart, M. D.

10/20, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn, Cem.	Oct 23 1921

20 UNDERTAKER John H. Toadvine ADDRESS 142 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57949

CERTIFICATE OF DEATH.

109

D 57949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Mt. Grand Road St.: 24 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Leroy Young.

(a) RESIDENCE. No. 508 East Barney St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1. 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1.	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Carrie Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) John Young 508 E. Barney St

15 Filed Robert P. Harrison, Registrar

T 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21. 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18. 1921, to Oct. 21, 1921, that I last saw him alive on Oct. 21, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia

(duration) yrs. mos. 2. ds.

CONTRIBUTORY (Secondary) Post Operative Intestinal Obstruction.

(duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Oct. 18. 1921

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John W. Mc Clenahan, M. D.

, 19 (Address) Mt. Grand Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	10/24 1921
20 UNDERTAKER	ADDRESS
E. F. McCully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 57950

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 Col 1 D 57950

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2205 Barclay St Ward 17)

2 FULL NAME Mary Anna Matthews

(Residence in Baltimore: No. 220 S Barclay St.; 90 yrs. about mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: ~~Feb~~ Feb. 22nd, 1848 (Month) (Day) (Year)

7 AGE: 73 yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: No occupation
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9 BIRTHPLACE (State or country): Baltimore Co.

PARENTS

10 NAME OF FATHER: Mordecai Matthews

11 BIRTHPLACE OF FATHER (State or country): Balto. Co.

12 MAIDEN NAME OF MOTHER: Philena Lamb

13 BIRTHPLACE OF MOTHER (State or country): Balto. City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Tucker
(Address) Park Ave

15. Robert P. Harrison,
Filed ..... 191 Burial Permit Clerk. REGISTRAR

CT 2 21921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 20 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1921. to Oct. 20th 1921. that I saw her alive on Oct. 20th 1921. and that death occurred, on the date stated above, at 6.20 p m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
+ loss of Compensation of heart
(Terminal Disease.) (Duration) ..... yrs. ..... mos. 5 ds
Contributory (SECONDARY) Arterio Sclerosis
(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) J. Dawson Reader M. D.
Oct. 20th 1921. (Address) 308 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Friends Cemetery — DATE OF BURIAL: Oct 24 1921

20 UNDERTAKER: John O'Mitchell — ADDRESS: 420 N. Gay St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57951

D 57951

CERTIFICATE OF DEATH.

149

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 W. Franklin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Burbank

(a) RESIDENCE. No. 822 W. Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary O. Burbank

6 DATE OF BIRTH (month, day, and year) 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER David Burbank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Sophie Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Sophie F. Burbank
(Address) 822 W. Franklin St

15 Filed 2 2 1921 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 —, 1921, to Oct. 21 —, 1921, that I last saw h— alive on Oct. 20 —, 1921, and that death occurred, on the date stated above, at 4- a. m.

The CAUSE OF DEATH* was as follows:

Muscular Rheumatism & inanition

(duration) about 3 or 4 months. yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical examination

(Signed) Carlton McCook, M. D.

, 19 (Address) 1107 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 24 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57952

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 N. Calhoun St. 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny D. Ogle.

(a) RESIDENCE. No. 609 N. Calhoun St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Richard D Ogle

6 DATE OF BIRTH (month, day, and year): June 13/42

7 AGE: Years 79 | Months 4 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vermont.

PARENTS

10 NAME OF FATHER: Asa Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Vermont

12 MAIDEN NAME OF MOTHER: Susan Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Vermont

14 Informant (Address): F T. Ogle 609 N Calhoun St.

15 Filed 19 Robert P. Harrison, Registrar

22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1916, to Oct 20, 1921, that I last saw her alive on Oct 17, 1921, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 10 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. E. Krutch M. D.

Oct 21, 1921 (Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 22 1921

20 UNDERTAKER: J D Mitchell — ADDRESS: 1201 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57953

CERTIFICATE OF DEATH.

92

D 57953

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 S. Decker. ST.: 1 WARD)

2-FULL NAME Elizabeth Taylor.

(a) RESIDENCE. NO. 506 S. Decker Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Julius Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Louisa Bolties.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Julius Taylor 506 S. Decker Ave.

15 Filed 19 Robert P. Harrison, Registrar

OCT 22 1921 Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to Oct 20, 1921, that I last saw her alive on Oct 20, 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ? yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. L. Tumbleson, M. D.

Oct 22 1921 (Address) 2013 Bank.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct. 22 1921
20 UNDERTAKER Lilly & Ziler.	ADDRESS 403 S. Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57954

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 57954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 Eastern Ave. ST. 76 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Herda

(a) RESIDENCE. No. 3313 Eastern Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paul Herda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Groff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Paul Herda

(Address) 3313 Eastern Ave.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

CT 221921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from October 19, 1921, to October 20, 1921, that I last saw he alive on October 20, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

(Premature Birth six months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Allen C Beecham, M. D.

Oct 19, 1921 (Address) 3139 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnsville Cem.	Oct. 22 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 57955 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57955

CERTIFICATE OF DEATH. 157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Westwood Ave. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Gibb Allmutt

(a) RESIDENCE No. 3206 Westwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/20/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER E C Allmutt

11 BIRTHPLACE OF FATHER (city or town) Carrsville
(State or country) Md

12 MAIDEN NAME OF MOTHER Lucie Fox.

13 BIRTHPLACE OF MOTHER (city or town) Dowsonville
(State or country) Md

14 Informant E. C. Allmutt
(Address) 3206 Westwood Ave

15 Nov 4 1921, 19 Registrar

Robert P. Harrison,
Registrar Vital Statistics.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20 1921

17

I HEREBY CERTIFY, That I attended deceased from 10/20, 1921, to 10/20, 1921,

that I last saw him alive on 10/20, 1921,

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Congenital obstruction of bile duct

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas H Hartman, M. D.

, 19 (Address) 39 W. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bellsville Md	10/22 19 21
20 UNDERTAKER E & B. Hanle	ADDRESS 115 E. Mt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57956

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH Mt Washington

CITY OF BALTIMORE: (No. South Rd & Highland Ave ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Erving G. Bloom

(Residence in Baltimore: No. South Rd & Highland Ave St.; ..... yrs., 2 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug 7, 1919
(Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 13 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Millard O Bloom

11-BIRTHPLACE OF FATHER (State or Country) Balto Co.

12-MAIDEN NAME OF MOTHER Clara Whatley

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M O Bloom

(Address) South Rd & Highland Ave

15-

Robert P. Harrison,

Filed ....., 191.....

T 22 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH October 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Oct 20 1921, that I saw h.er alive on Oct 20 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

..... (Duration) yrs. 2 mos. 13 ds.

CONTRIBUTORY convulsions
(Secondary)

..... (Duration) yrs. ..... mos. 1/2 ds.

(Signed) L. R. Wantz M. D.

Oct 21, 1921 (Address) 865 W 36th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Druid Ridge DATE OF BURIAL, Oct 22, 191..

20-UNDERTAKER D S Marshall ADDRESS 3529 Falls Rd

CAUSE OF DEATH to be plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57957 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57957

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Brown

(a) RESIDENCE. No. 1725 McCullough St. ST., WARD. 14th

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Sam. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Amelia Dayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records,

(Address) New City Hospital,

15 Filed 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from August 23, 1921, to October 21, 1921 that I last saw him alive on October 21, 1921 and that death occurred, on the date stated above, at 11:00 A.m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene Left Foot.

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Operative Shock

(duration) yrs. mos. 1 hr.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Oct. 21-1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E E Broadrup, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Holabird Cem	Oct 24 1921
20 UNDERTAKER George H. Holland	ADDRESS 1631 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57958

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Cordner & Allegania ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Vetrovsky

(Residence in Baltimore: No. 641 S Decker Ave St.; yrs., 51 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 79 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country). Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Vetrovsky
(Address) 641 S Decker Ave

15-
Filed ....., 191.....
Robert P. Harrison, Burial Permit Clerk. Registrar.

221921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) I find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Lyon M. D.
(Coroner)
Oct 31, 1921 (Address) 1009 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov 2, 1921
20-UNDERTAKER	ADDRESS
Frank Ulrich Son	1924 Ashland ave

Spec.—1-10-21—M&T—1500 Bks.

D 57959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57959

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N. Kenwood Ave, 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J Watson

(a) RESIDENCE No. 100 N Kenwood Ave, WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 20-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas E. Watson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah E. Darby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Sarah E. Watson (Address) 100 N Kenwood.

15 Filed OCT 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to Oct 18, 1921, that I last saw him alive on Oct 17, 1921, and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows: Chronic Bright's Kidney Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. A. Hagen M. D.

Oct 19, 1921 (Address) 7600 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 22 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons.	1110 East St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57960

CERTIFICATE OF DEATH.

120

D 57960

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 838 Woodward ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E Godwin

(a) RESIDENCE. NO. 838 Woodward ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Emma Godwin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Emma Godwin

(Address) 838 Woodward St

15 Filed J 22 1921

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/1921

17 I HEREBY CERTIFY, That I attended deceased from 10/19, 1921, to 10/19/21, 19..., that I last saw h i alive on 10/21/21, 19..., and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Bilious Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen D Mason, M. D.

, 19 (Address) 1929 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Woodlawn

DATE OF BURIAL: Oct 24 1921

20 UNDERTAKER: Geo W Little

ADDRESS 2700 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57961

CERTIFICATE OF DEATH.

64 ✓ D 57961

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 122 b N. Washington ST.; (8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Brown

(a) RESIDENCE. (Usual place of abode) No. 122 b N. Washington ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Brown

6 DATE OF BIRTH (month, day, and year) July 17 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wm. York Wm. York

PARENTS

10 NAME OF FATHER Geo. Brown

11 BIRTHPLACE OF FATHER (city or town) Wm. York (State or country) Wm. York

12 MAIDEN NAME OF MOTHER Mabey —

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) —

14 Informant Rose Brown (Address) 122 b N. Washington St

15 Filed 19 Robert P. Harrison, Registrar

T 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1920, to October 20, 1921, that I last saw h[illegible] alive on October 19 1921, and that death occurred, on the date stated above, at 8408 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - Final

and paralysis of muscles of deglutition

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) paralysis of muscles of deglutition

[illegible] — (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? [illegible]

(Signed) Irving Miller, M. D.

, 19 (Address) 10 E. North Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 24 1921
20 UNDERTAKER Geo. Weber & Son	ADDRESS 2503 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

D 57962 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57962

155

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1 Jewish Hospital St., 8 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adeles Seutter

(Residence in Baltimore: No. 1508 n Chester st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH Jan 18, 1889
(Month) (Day) (Year)

7-AGE, 32 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) DA

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER Jos Seutter.

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Emma nonel

13-BIRTHPLACE OF MOTHER (State or Country). Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adeles Seutter
(Address) 1508 Chester

15- Robert P. Harrison,
Filed ....., 191.... Registrar.

OCT 22 1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide by Bichloride
Tabs
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J R Insley M. D.
(Coroner.)
Oct 22, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct 24, 1921

20-UNDERTAKER Robt Tenner & Bro. ADDRESS

R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57963

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 57963

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 508, Ravenswood, Ave, Govans St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Francis Conary.

(Residence in Baltimore: No. 508, Ravenswood, Ave. Govans. Md. St.; 6 yrs., 10 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	single

6-DATE OF BIRTH, Dec. 11, 1914, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
6 yrs. 10 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer)..... School

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Elwood H. Conary

11-BIRTHPLACE OF FATHER (State or Country), Me.

12-MAIDEN NAME OF MOTHER Ethel M. Winterbottom

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elwood H. Conary
(Address) 508, Ravenswood, Ave. Govans, Md.

15-

Filed ..... Robert P. Harrison, ...
Registrar.

T 22 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 20, 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/20/21 191..., to 10/20/21 191..., that I saw Him alive on 10/20/21 191..., and that death occurred, on the date stated above, at 10. P m.

The CAUSE OF DEATH* was as follows:
Acute Nephritis, & Uraemic Poisoning
9 Hours
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions
(Duration) ..... yrs. 2 Hours mos. ..... ds.

(Signed) J. Boyston Green M. D.
10/21/21 (Address) Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, Oct 22, 1921.

20-UNDERTAKER E. A. Windfield Jr. ADDRESS 501 E 22

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57964

CERTIFICATE OF DEATH.

54 D 57964

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2256 Linden Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Dannenberg

(a) RESIDENCE. NO. 2206 Linden Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Ernst Dannenberg

6 DATE OF BIRTH (month, day, and year): Oct 18th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 027

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West Prussia

PARENTS

10 NAME OF FATHER: Louis Dannenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Prussia

12 MAIDEN NAME OF MOTHER: Rosie Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Cohen

14 Informant: Mrs Dannenberg

(Address): 2206 Linden Ave

15 Filed OCT 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21st 1921

17

I HEREBY CERTIFY, That I attended deceased from August, 1920, to Oct 21, 1921,

that I last saw h[illegible] alive on Oct 21, 1921,

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Samuel Hollander, M. D.

, 19 (Address) 1342 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Oct 23 1921
20 UNDERTAKER	ADDRESS
David Bondheim	1128 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

City Please Call ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57965

CERTIFICATE OF DEATH.

151 D 57965

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 871 Hollins ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mattingly

(a) RESIDENCE. NO. 871 Hollins ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/21/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 24 min.
	Stillborn	(4 mo)		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Mattingly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine A Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant
(Address)

15 Filed OCT 22 1921 Robert P. Garrison, Registrar
(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/21

17 I HEREBY CERTIFY, That I attended deceased from 10/21/2119 to 10/21/21, 19,
that I last saw h[illegible] alive on 10/21/21, 19,
and that death occurred, on the date stated above, at 1.20 A m.
The CAUSE OF DEATH* was as follows:

Immaturity
4 mo. 24

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Jenny, M. D.

OCT 2, 19 21 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL.	19
20 UNDERTAKER	ADDRESS OCT 2 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57966

CERTIFICATE OF DEATH.

175.00

REGISTERED NO. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Church Home St. 1 WARD) — (If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Stanislaus Blachowicz

(Residence in Baltimore: No. 412 1 Madeira St. 7 yrs., 9 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, January (Month) 16 (Day), 1914 (Year)

7-AGE, 7 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): Boy.

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Joseph Blachowicz.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Katharine Lipka.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Blachowicz.

(Address) 417 S. Madeira St.

15-

Filed ..... 1921 Robert T. Harrison. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: rheumatism heart by Colds (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. F. Sadler (Coroner) M. D.

10-27, 1921 (Address) 1426 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus Cem.	Oct 24, 1921
20-UNDERTAKER M. F. Sadowski	ADDRESS 905 S. Ann St.

Burial Permit Clerk.

11—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57967 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57967

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3229 Clifton Ave ST.: Walbrook 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Johnson

(a) RESIDENCE. No. 3229 Clifton Ave ST., (Walbrook) WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor, Apartment

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jarrett Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma T. Johnson

(Address) 3224 Clifton Ave

15 Filed ..... 19 ..... Registrar

T 22 1921 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/21

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Oct 21, 1921, that I last saw him alive on Oct 21, 1921, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Arth.

(duration) " yrs. " mos. " ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Jas. Stoulton, M. D.

10/21/21 (Address) 6303 Windsor Mills Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

20 UNDERTAKER George H. Holland

DATE OF BURIAL OCT 23 1921

ADDRESS 1631 Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of certificates. TION is very important. See instructions on back of cer

Volpeta

57968 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 57968

D 57968

CERTIFICATE OF DEATH.

150

D 57968

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 376 Forest ST.: 10 WARD)

REGISTERED NO. C 968

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Volpeta

(Residence in Baltimore: No. 376 Forest St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	S.

6-DATE OF BIRTH, Oct 12 1921
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Nathale Volpeta

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER L. Malazo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Volpeta

(Address) 376 Forest St

15- Filed OCT 23 1921 ROBERT A KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said None (Inquest, autopsy or inquiry.) and that said deceased came to ✓ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia, Acute Lobar ✓
Contributory Heart Failure ✓

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas Reilly M. D.
(Coroner.)

Oct 22, 1921 (Address) 1659 Lucy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincent Cemetery	Oct 22 1921
20-UNDERTAKER	ADDRESS
George - J. Ruth	1735 Harford Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Bks.

D 57969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57969

CERTIFICATE OF DEATH.

78

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Poplar Ave Overleast (ST.) 27 (WARD)

2-FULL NAME Gertrude M Ulrich

(a) RESIDENCE No. Poplar Ave Overleast (ST.) ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Ulrich

6 DATE OF BIRTH (month, day, and year) May 15 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	46	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisburg Pa

PARENTS

10 NAME OF FATHER William T Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Pa

12 MAIDEN NAME OF MOTHER Mary C Buerck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Pa

14 Informant William H Ulrich (Address) Poplar Ave Overleast

15 Filed OCT 23 1921 ROBERT E KRAUSE Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th 1920, to Oct 20th 1921, that I last saw h.. alive on Oct. 20th 1921, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phtisis

about (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) about 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) E. E. Fonrey M. D.

21 Oct 1921 (Address) 908 E Shaft

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: Oct 24 1921

20 UNDERTAKER: Williamcock ADDRESS: 502 E North Ave

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 156 D 57970

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4119 Fredericks Rd ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathan Magit

(Residence in Baltimore: No. 4119 Fredericks Rd St.: yrs., mos. 6 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ~~Sept~~ June 12, 1848
(Month) (Day) (Year)

7-AGE, 73 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Glazier
(b) General nature of industry, business, or establishment in which employed (or employer)..... himself

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Hyman Magit

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Magit

(Address) 4119 Fredericks Rd

15- OCT 23 1921 ROBERT J. KRAUTER

Filed....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage by Internal Violence

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Mental depression

(Duration) yrs. mos. da.

(Signed) James W Fenton M. D.
(Coroner.)

Oct 22 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence New York

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship DATE OF BURIAL, Oct 24 1921

20-UNDERTAKER Sol Grinson ADDRESS 1001 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57971 ✓ 172 D 57971

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonio Livio.

(Residence in Baltimore: No. 25 N. Central Ave. St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. (Month) (Day), 1 (Year)

7-AGE. 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brick layer & helper.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Italy.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josepnine Louicn.

(Address) 25 N. Central Ave.

Filed OCT 23 1921 191 [illegible] Registrar.

COHONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20th. 1921 (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage due to a rupture of the liver.
Occidental fall with a scaffold loaded with brick.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Country)

Oct 23, 1921 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Sugar Refinery Locust Point.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem.	10/24/21
20-UNDERTAKER	ADDRESS
Randall Dippel & Son	37 S Carey St

Spec.—1-10-21—M&T—1500 Blks.

D 57972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57972

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1817 E. Pratt ST., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Missler

(a) RESIDENCE NO. 1817 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Missler

6 DATE OF BIRTH (month, day, and year) Unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Charles Missler

(Address) 1817 E. Pratt St.

15 OCT 23 1921

MOVER'S STAMP

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1921, to Oct. 22, 1921, that I last saw her alive on Oct. 21, 1921, and that death occurred, on the date stated above, at 4 35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Organic Heart disease (Examined Pat. about 6 months ago)

Long (duration) yrs. ? mos ! ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Frank J. Smith, M. D.

, 19 (Address) 924 E. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 10/23 1921

20 UNDERTAKER Jack Lewis

ADDRESS 1411 S. Bond St

MATION should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

D 57973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57973

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH Hebrew aged Home 2001 E Baltimore REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Non Curable ST., 3 WARD)

2-FULL NAME Mary Kaplan

(a) RESIDENCE NO. 1114 E Pratt ST ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pesach Kaplan

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 1411 E Balto St

15 Filed OCT 23 1921 ROBERT A KRAUTER Registrar

Serial Permit Used

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921, to Oct 22, 1921, that I last saw h[illegible] alive on Oct 21, 1921, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:
bronchial asthma

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Lehrhaum, M. D.

, 19 (Address) 1392 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Nursing Rm DATE OF BURIAL 10/23 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Horney. ✓

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57974

HEALTH DEPARTMENT—CITY OF BALTIMORE

64D 57974

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 N. Cay ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Horney

(a) RESIDENCE. NO. 1012 N. Cay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S. If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Horney

6 DATE OF BIRTH (month, day, and year) May 10, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Supt. of Cemetery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Solomon Horney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Tarr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie Horney (Address) 1012 N. Cay St.

15 OCT 23 1921 ROBERT A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to Oct 22, 1921, that I last saw h[illegible] alive on Oct 22, 1921, and that death occurred, on the date stated above, at 9 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1012 N Cay

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alfred Gagl, M. D.

, 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Oct. 24 1921

20 UNDERTAKER Wm. C. Black 927 N. Broadway ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D 57975

D 57975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 523 S Chester ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Banach

(a) RESIDENCE NO. 523 S Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Marion Banach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Enthoustel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Marion Banach
(Address) 523 S Chester St

15 OCT 23 1921 ROBERT J. KRAUTER Registrar
Health Board Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1921, to Oct 23, 1921

that I last saw living on Oct 22, 1921

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Failure

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Intra Uterine Disease

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) M Fenderson, M. D.

(Address) 600 N Dukeman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 23 1921
20 UNDERTAKER John M Weber	ADDRESS 1803 Hank st.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57976

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter A. Raleigh

(a) RESIDENCE. No. Allston Apts Charles 32nd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~THE WIFE of~~ Mrs Walter Raleigh

6 DATE OF BIRTH (month, day, and year) Jan. 4. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Walter A Raleigh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sabrina Savage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Walter A. Raleigh
(Address) Allston apts Charles 32nd

15 Filed OCT 23 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1921, to Oct 21, 1921, that I last saw h.m alive on Oct 21, 1921, and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon (Sigmoid)

Symptoms from May 1921
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 8 Oct 20 '21

Was there an autopsy? No.

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Edward Hanrahan Jr. M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Oct 22/ 1921.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57977

CERTIFICATE OF DEATH.

D 57977

102-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Solzman

(a) RESIDENCE. NO. 1914 E. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Yetta Salzman

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E Balto St

15 OCT 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Oct 23rd, 1921, that I last saw him alive on Oct 23rd, 1921, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) General Pretonitis after Ruptured Gastric Ulcer (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/18/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles S. Levy, M. D.

10-23-1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	10/23 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57978

D 57978

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No Nursery & Childs Hosp. ST. 18 WARD)

2-FULL NAME Samuel Arthur Witz

(a) RESIDENCE. No. Schroeder & Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 '20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Howard John Witz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret Maggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Margaret Witz
(Address) Nursery and Childs Hosp

15 DATE RECEIVED OCT 23 1921 ROBERT E KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1921, to Oct 22nd, 1921, that I last saw him alive on Oct 22nd, 1921, and that death occurred, on the date stated above, at 9:05 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil F Meisgeier, M. D.

, 19 (Address) 1001 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 24 1921
20 UNDERTAKER	ADDRESS 1000 E
George J Smith	Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 57979

CERTIFICATE OF DEATH

150 D 57979

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2835 E Erdman Av ST.; 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Eckels

(Residence in Baltimore: No. 2835 E Erdman Av St.; yrs. 9 mos. 4 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ WIDOWED OR ~~DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: January (Month) 16 (Day), 1911 (Year)

7 AGE: yrs. 9 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Arthur J Eckels

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Hanna M Miller

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur J Eckels

(Address) 2835 E Erdman Ave

15

DATE RECEIVED: OCT 23 1921 ROBERT J. ... REGISTRAR

Burial Permit Mark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 21 (Day), 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1921, to Oct 21, 1921, that I saw h[er] alive on Oct 20, 1921, and that death occurred, on the date stated above, at 1:25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. 9 mos. 4 ds

Contributory (SECONDARY) Convulsions

(Duration) yrs. mos. ds.

(Signed) John Chatwick M. D.

Oct 21, 1921 (Address) 11 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted. If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Oct 24, 1921

20 UNDERTAKER: Geo J Smith

ADDRESS: 1000 E Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks. John P. Ruehl

D 57980 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 170 D 57980

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3150 Leede Street ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P Ruehl

(a) RESIDENCE. No. 3150 Leede St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Ruehl.

6 DATE OF BIRTH (month, day, and year) May 7 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oct 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Ruhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Hall Oct 21, 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jno. Ruhl (Address) 3150 Leede St

15 Filed OCT 23 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1921, to Oct 20, 1921, that I last saw h.. alive on Oct 20, 1921, and that death occurred, on the date stated above, at 9 20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos H Claytor M. D.

Oct 21, 1921 (Address) 1500 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct. 24, 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 N Fayette St.

A. B. C. Form 3—Rev. 1919

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3908 Keteav ST.: 15 WARD)

REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet L. Doll

(a) RESIDENCE. No. 3908 Keteavy ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard P. Doll

6 DATE OF BIRTH (month, day, and year): 5-5-1856.

7 AGE 65 Years 5 Months 12 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Richd Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Stover

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Bernard P. Doll
(Address) 3908 Keteavy

15 Filed OCT 23 1921 ROBERT J. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-21- 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1921, to Oct 20-, 1921, that I last saw her alive on Oct. 20-, 1921, and that death occurred, on the date stated above, at 7. a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Robt J. Sanders M.D.

, 19 (Address) Main & Hayward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 24

20 UNDERTAKER: George J. Smith

ADDRESS: 220 W. Fayette St.

D 57982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57982

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersity Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Pearl Johnson

(Residence in Baltimore: No. Elkridge Howard Co Md St.; yrs., mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laboror
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw L. Odonnell

(Address) Elkridge Howard Co Md

15- Filed OCT 23 1921 ROBERT F. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry) thereon and from the evidence obtained by said ..... ~~(Inquest, au-~~ ..... (topsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Cuts & Contusions

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) H. T. Longnecker M. D.
(Coroner.)

10-22-1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Elkridge Md.

19-PLACE OF BURIAL OR REMOVAL, Mt. Gilboa Cem. DATE OF BURIAL, Oct 24 1921

20-UNDERTAKER Easton Coms ADDRESS Ellicott City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57983

CERTIFICATE OF DEATH.

X 126

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John H. Naylor

(a) RESIDENCE No. Dover, Pa. ST., WARD.

(If nonresident give city or town and State) Dover Pa

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Elizabeth Naylor

6 DATE OF BIRTH (month, day, and year): June 18, 1861

7 AGE — Years: 60 Months: 4 Days: 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Robert Naylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Sarah Grove

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Harvey Naylor York Pa

15 Filed . 19 Registrar

OCT 24 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Oct. 23, 1921, that I last saw him alive on Oct. 23, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation (duration) yrs. mos. 1/2 Hr ds.

18 Where was disease contracted if not at place of death? Prostatectomy

Did an operation precede death? yes Date of Oct 1

Was there an autopsy? no

What test confirmed diagnosis? Typical Symptoms

(Signed) John H. Booth M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Pa

DATE OF BURIAL: Oct 24 19

20 UNDERTAKER: Joseph Ahrens

ADDRESS: 226 W Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PARTICULARS of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 57984
1 PLACE OF DEATH

152 D 57984
REGISTERED No. C

CITY OF BALTIMORE (No. Hollins Ferry Road [illegible] ST.: 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Morris (Morris)

(Residence in Baltimore: No. Hollins Ferry Road ST.: yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col'd

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct. (Month) 20 (Day), 1921 (Year)

7 AGE: ..... yrs. mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Morris

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Gertrude Oliver

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Morris

(Address) Hollins Ferry Road

15 Filed OCT 24 1921, 19.. ROBERT J. KRAUSE Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 22 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1921, to Oct. 22, 1921, that I saw h[illegible] alive on Oct. 22, 1921, and that death occurred, on the date stated above, at 10.30 a. m.
The CAUSE OF DEATH* was as follows:

Hemorrhage of Umbilicus

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. H. Wood M. D.

Oct. 23, 1921 (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Calvary Cem

DATE OF BURIAL: Oct 25 1921

20 UNDERTAKER: Bauer & Swinley

ADDRESS: 1111 Bolton St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57985 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57985

CERTIFICATE OF DEATH. X 1

1-PLACE OF DEATH

CITY OF BALTIMORE: No. University Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garrison L. Bennett.

(a) RESIDENCE. No. Marriottsville, Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Bennett

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer - 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant P. T. Hammond (Address) Marriottsville Md

15 Filed OCT 24 1921, 19 ROBERT S. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1921, to Oct. 24, 1921, that I last saw him alive on Oct. 24, 1921, and that death occurred, on the date stated above, at 6:00 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever -

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Marriottsville, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs. Lab. findings

(Signed) W. S. Jones, M. D.

10/24/1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Humicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville Md	Oct 26 1921
20 UNDERTAKER	ADDRESS
Jas. R. Weer	Sykesville Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57986 ✓ D 57986

151

CERTIFICATE OF DEATH.

D 57986

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1562 Ridgely ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Ruth Creamer

(a) RESIDENCE NO. 1562 Ridgely ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1921

7 AGE	Years	Months	Days	If LESS than 1 day 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ——— God

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George L. Creamer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Helen Sheppard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): George L. Creamer 1562 Ridgely

15 OCT 24 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1921, to Oct 23, 1921, that I last saw h[illegible] alive on Oct 23, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth
7 months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Bowley Young, M. D.

(Address) 724 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct. 24 1921

20 UNDERTAKER: James Pignan & Son — ADDRESS: 1000 S. Paca St

N. B. WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57987.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 222 Jasper St- St.; 4 Ward) REGISTERED No. C 89

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Chandler

(Residence in Baltimore: No. 222 Jasper st St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov (Month) 19 (Day), 1920 (Year)

7-AGE, ...yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Charles Chandler

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Theresa Colbert

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Colbert

(Address) 222 Jasper St.

15- OCT 24 1921 Filed ..... 191.... ROBERT A. LEAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Jurors, or Surgeon or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Bronchitis

(Duration) .... yrs. .... mos. 4 ds.

CONTRIBUTORY (Secondary) Old age.

(Duration) .... yrs. .... mos. 4 ds.

(Signed) W. K. Jones M. D. (Coroner)

1027, 192[illegible] (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 25 1921

20-UNDERTAKER Forrow Hall

ADDRESS 1741 E Hoff

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57988 CERTIFICATE OF DEATH. 53 D 57988

1-PLACE OF DEATH University Hospital - REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Landenslager -

(a) RESIDENCE. NO. 3843 Falls Road - Balto. - WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~Wife of~~ Geneva Landenslager

6 DATE OF BIRTH (month, day, and year) Aug 15 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Louis Landenslayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Graunstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geneiva Landenslayer
(Address) 3843 Falls Road

15 Filed OCT 24 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-12, 1921, to 10-23, 1921, that I last saw him alive on 10-23 -, 1921, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Sylens - Myelogenous Leukemia -

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 3843 Falls Road

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) N B Jones, M. D.

10 23, 1921 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Oct 25 1921
20 UNDERTAKER	ADDRESS
Wm Cat	526 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT (Ruil) CITY OF BALTIMORE

D 57989

CERTIFICATE OF DEATH.

105 D 57989

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 N. Rose ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Elizabeth Ruil

(Residence in Baltimore: No. 234 N. Rose St St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, April 9-1919, 1 (Month) (Day) (Year)

7-AGE, 2 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER, Fert Ruil

11-BIRTHPLACE OF FATHER (State or Country), Holland

12-MAIDEN NAME OF MOTHER Alice Steiser

13-BIRTHPLACE OF MOTHER (State or Country), Northumberland Co. Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Ruil

(Address) 234 N. Rose St

15- GES

Filed....., 191.....

OCT 24 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10/23-21, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/4/21 191..., to 10/23/21 191..., that I saw her alive on 10/22/21 191..., and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

..... (Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Secondary Anemia

..... (Duration) yrs. mos. 15 ds.

(Signed) D.S. Foreman M. D.

P.O. ....., 191... (Address) 919 S. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Schwartz — DATE OF BURIAL, Oct. 25/21 191...

20-UNDERTAKER Wm. Cook. — ADDRESS 502 E. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57990 ✓ D 57990

CERTIFICATE OF DEATH.

78

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. Elwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Bussman

(Residence in Baltimore: No. 118 S. Elwood Ave, St.; life yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. (Month) 16 (Day), 1869 (Year)

7-AGE, 52 yrs. 8 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wood Moulder
(b) General nature of industry, business, or establishment in which employed (or employer): Otto Dulin & Co.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Bussman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Bussman

(Address) 118 S Ellwood Av.

15-

Filed ....., 191.....

OCT 24 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1921, to Oct 22 1921, that I saw h[im] alive on Oct 21 1921, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows;

Endocarditis

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. S. Preston M. D.

Oct 24, 1921. (Address) 1711 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Oct. 25..., 1921

20-UNDERTAKER H. Sanders Son

ADDRESS 1710 Pat St.

D 57991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57991

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital St.: 13 WARD) 175-0

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert W. Wheats

(Residence in Baltimore: No. 703 Carwell Ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, April (Month) 25 (Day), 1915 (Year)

7-AGE, 6 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Walter R Wheats

11-BIRTHPLACE OF FATHER (State or Country) Granit md

12-MAIDEN NAME OF MOTHER Harriet Musgrove

13-BIRTHPLACE OF MOTHER (State or Country), Woodlawn md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter R Wheats

(Address) 703 Carwell ave

15-

Filed OCT 24 1921 W.C. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage into Peritoneal Cavity, due to Auto accident

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jones M. Fenton M. D. (Coroner.)

Oct 23 1921. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death St Agnes Hosp In the State yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted if not at place of death? Carwell & Chesnut aves

Former or usual residence 703 Carwell ave

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem DATE OF BURIAL, Oct 25, 1921

UNDERTAKER Wm Cook ADDRESS 509 E North ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57992

CERTIFICATE OF DEATH.

D 57992

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N. Patterson Park Ave ST., 6 WARD)

2-FULL NAME Dorathea Streifler

(a) RESIDENCE No. 404 N. Patterson Pk Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frederick Streifler

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Fuchs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. L. Fuchs

(Address) 404 N Patterson Pk Ave.

15 Filed OCT 24 1921 LL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1 1921, to Oct 22 1921,

that I last saw h[illegible] alive on Oct 19 1921,

and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Senility - Cala. Hy - Arteriosc -

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Bronchitis Subacute

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) M. E. Brunner, M. D.

. 19 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Oct 24 1921

20 UNDERTAKER: H. Gonder & Sons — ADDRESS: 1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL ENTRIES SHOULD BE MADE WITH THIS IN MIND. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57993 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57993

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 W Fayette St. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Fuller Gregory

(a) RESIDENCE. NO. 2608 W Fayette ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Gregory

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER Oliver P. Gregory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston S. C.

12 MAIDEN NAME OF MOTHER Annabella Bonting

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt md

14 Informant Mrs Annabella Gregory (Address) 1242 Bargent St

15 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/ 1921

17

I HEREBY CERTIFY, That I attended deceased from August, 19 21 to Oct 21, 19 21, that last saw h[illegible] alive on Oct 21, 19 21 and that death occurred, on the date stated above, at 5:9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Ulcer.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. State Dan Exam

(Signed) Stuart Brain, M. D.

, 19 (Address) 1127 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balt Cemetery	Oct 24th 1921
20 UNDERTAKER	ADDRESS
Geo Leinbach & Son	647 W Balt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57994

CERTIFICATE OF DEATH.

167 W. Pk. Commissioners

D 57994

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3201 E Lombard St. No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wilson Coyne

(a) RESIDENCE No 3201 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Oct 6-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Jessie Coyne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Kate Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn.

14 Informant (Address): Jessie Coyne 3201 E Lombard St

15 Filed OCT 24 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to Oct. 22, 1921, that I last saw him alive on Oct 22, 1921, and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Card. (Thrombosis) Coronary

Upper part of entire body

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. O. Chesney, M. D.

Oct 23, 1921 (Address) 330 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Bom — DATE OF BURIAL: 10-24 1921

20 UNDERTAKER: J A Moran — ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57995 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57995

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 N. Linwood Ave. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Sattler

(a) RESIDENCE. No. 729 N. Linwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Sattler

6 DATE OF BIRTH (month, day, and year) Aug 23-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alsace Lorraine France

PARENTS

10 NAME OF FATHER John Baumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) France.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Lena Sattler
(Address) 729 N. Linwood Ave.

15 Filed OCT 24 1921, 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1921, to October 22, 1921, that I last saw her alive on October 21, 1921, and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis -
Chronic Myocarditis.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Schmidt, M. D.

Oct 22 1921 (Address) 701 Aisenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Oct. 25 1921
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of AGE is very important. See instructions on back of certificates.

(Vacater)

D 57996 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 57996
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 900 Park ST. 26 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Wachter
(Residence in Baltimore: No. 900 Park pl St.: yrs., 56 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should have CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Married

6-DATE OF BIRTH, April 12, 1865 (Month) (Day) (Year)

7-AGE: 57 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Germany

PARENTS.
10-NAME OF FATHER: Andrew Wachter
11-BIRTHPLACE OF FATHER (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Helen Gehrig
(Address) 900 Park Ave

15-
Filed OCT 2-1922 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally killed by fall from second story window

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas Ryan Kelly M. D. (Coroner.)
Oct 24 1922 (Address) 15 S 9 Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL, Oct 27, 1922
20-UNDERTAKER: Kelly & Zeller ADDRESS: 403 S. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

(over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57997

CERTIFICATE OF DEATH.

D 57997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3722 Gough St. 4th WARD)

2-FULL NAME Fredk Harwood

(a) RESIDENCE. NO. 3722 Gough ST., East WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6m	6m	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) 3722 Gough St
(State or country) Md

PARENTS

10 NAME OF FATHER Fredk Harwood

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Bolte

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Augusta Harwood
(Address) 3722 Gough St

15 Filed OCT 24 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 23 Oct 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to Oct 23, 1921, that I last saw h.... alive on ....., 19....., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Marasmus
Lung Affection
Emphysema

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary) .....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E W Lamy, M. D.

, 19 (Address) 3602 Boundary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 24 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This child has been
at the Hospital
— infant —
2 months.
for Nursing Dixon
E. W. Jones M.D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57998

CERTIFICATE OF DEATH.

D 57998

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersey Hospital ST. 14 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Smith

(Residence in Baltimore: No. 547 Mosher St. St. 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH. Don't Know, 1 (Month) (Day) (Year)

7-AGE. 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Eda J Dennis

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Wells

(Address) 316 N Appleton St

15-

Filed OCT 24 1921

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest ~~subject to~~ inquiry) thereon and from the evidence obtained by said (Coroner, ~~to~~ inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) Don't Know yrs. mos. ds.

(Signed) W K Jones M. D. (Coroner)

10-24-1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. Oct 24, 1921

20-UNDERTAKER Brown & Buckler

ADDRESS 114 W

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57999

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

24/50

D 57999

REGISTERED No. C

CITY OF BALTIMORE (No. 1113 Hull Street. St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Acton.

(Residence in Baltimore: No. 1113 Hull St. ---------8. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White.	Single.

6-DATE OF BIRTH, October 20th, 1921. (Month) (Day), 1 (Year)

7-AGE. ---- yrs. ---- mos. 9 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Albert D. Acton.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Helen Young.

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Acton.(mother).

(Address) 1113 Hull Street.

15- FILED OCT 24 1921 191... [illegible] & KRAUTER Clerk Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 23rd. 1921. 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.
(Coroner.)

...., 191... (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	10/27/21 191...
20-UNDERTAKER	ADDRESS
John C. Fahey & Son	1318 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58000
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 445 W. Henrietta St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Blake. (C).

(Residence in Baltimore: No. 445 W. Henrietta St.

17 yr. ------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH. Do not know., (Month) 1 (Day) (Year)

7-AGE. 62 yrs. --- mos. ---- ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), St. Marys Co. Md.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willian Ennels. (C). (grandson.)

(Address) 445 W. Henrietta Street

15- FILED OCT 24 1921 191... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 22nd, 1921; 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto T. Reinhardt M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	Oct 25, 1921
20-UNDERTAKER	ADDRESS
R. L. Parham	648 N. Lee St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Parker.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58001

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 97 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel parker

(a) RESIDENCE. No. Melvale School ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer) School girl

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Parker

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jennie Parham

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 OCT 24 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from May 11, 19 21, to Oct. 21, 19 21, that I last saw her alive on Oct. 20, 19 21, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ... yrs. 9 mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in Sputum, X-ray

(Signed) Francis L. Dalrymple M. D.

10-21-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Oct 24 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58002

CERTIFICATE OF DEATH.

28

D 58002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Westwood Ave St.: 15 Ward)

2-FULL NAME S. Merritt McBride

(a) RESIDENCE. No. 3205 Westwood Ave St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine Winterling

6 DATE OF BIRTH (month, day, and year) June 23-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secy & Treas

(b) General nature of industry, business, or establishment in which employed (or employer) Meadlucker Tobacco Co. 386

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Saml McBride

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Mary Raleigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Catharine McBride (Address) 3205 Westwood Ave

15 Filed OCT 24 1921 Robert P. Kelsey Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1921, to Oct 23, 1921, that I last saw him alive on Oct 21, 1921, and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows: over

Abscess of Lt Lung.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart. 3 hours.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert G Webster M.D.

Oct 23 1921 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md — DATE OF BURIAL Oct 25 1921

20 UNDERTAKER John Herring & Co — ADDRESS 2008 Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly tuberculous.

D 58003

D 58003

D 58003

Sig.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 6 WARD)

2-FULL NAME Mrs Agnes Knight

(a) RESIDENCE. No. 2019 E. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward H. Knight

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Mercer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant E. H. Knight

(Address) 2017 E Fayette St. Balto Md

15 Filed OCT 24 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23 1921

17

I HEREBY CERTIFY, That I attended deceased from 10/17, 1921, to 10/23, 1921, that I last saw her alive on 10/23, 1921, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis Cholelithiasis Emphysema of Gall Bladder. Carcinoma of Head of Pancreas.

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cachexia Shock Cardiac decompensation. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 2019 E Fayette St

Did an operation precede death? yes Date of 10/21/21

Was there an autopsy? no

What test confirmed diagnosis? Palpation & sight at Laparotomy

(Signed) W. D. Douglass, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Oct 26 1921

20 UNDERTAKER John Lewis & Co

ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ...SICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. ...should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may ...may be properly classified. TION is very important. See instructions on back ...back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58004 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58004

REGISTERED NO.

1-PLACE OF DEATH U.S. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Domingo Moreno

(a) RESIDENCE NO. U.S. Public Health Hosp. #56 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Panama

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar

(Address) U.S. PHS Hosp. #56 Balto, Md.

15 Filed OCT 24 1921 ROBERT A. LEACH Registrar

Burial or removal

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921 to Oct. 20, 1921.

that I last saw him alive on Oct 20, 1921,

and that death occurred, on the date stated above, at 4'18 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

June 22, 1921 (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic Report

(Signed) Thomas B. Paynes M. D.

10/20 1921 (Address) Senior Surgeon (R) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Oct 25 1921

20 UNDERTAKER Jos Lauer

ADDRESS 1127 E Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58005 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58005

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital St.: 6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Mrs Annie Davis

(a) RESIDENCE. No. 317 N. Elwood ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of – John W. Davis

6 DATE OF BIRTH (month, day, and year) Apr. 4 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Fleming

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John W. Davis
(Address) 317 N. Elwood Ave

15 OCT 24 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1921, to Oct. 23, 1921, that I last saw her alive on Oct. 23, 1921, and that death occurred, on the date stated above, at 9:45a m.

The CAUSE OF DEATH* was as follows:

Papilloma right Ovary (malignant)
(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Cachexia
(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death Exploratory Laparotomy

Did an operation precede death? yes Date of Sept. 26, 1921

Was there an autopsy? no

What test confirmed diagnosis? Findings Signs & Symptoms

(Signed) John J. Cowen, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/26 1921
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	118 W. Mt Royal Ave

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be properly CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58006

D 58006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hosp — X 42

CITY OF BALTIMORE: (No. ST., 75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie E. Riley

(a) RESIDENCE NO. Emmitsburg, md ST., WARD Emmitsburg Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Head Maid

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: James Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Worrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs Edwin Rosensteel Emmitsburg Md

OCT 24 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/22/, 1921, to 10/24/, 1921, that I last saw h[illegible] alive on 10/24/21, 19 and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral Carcinoma of Ovaries with general metastasis.

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 9/25-21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) D. E. Caldwell, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Emmitsburg Frederick Co Md. DATE OF BURIAL Oct 24 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. Fayette ave

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

D 58007 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186 D 58007
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mmrsity Hospital ST.: 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Kozlowski
(Residence in Baltimore: No. 422 S. Bond. S. 14 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Dont Know (Month), 1 (Day), ... (Year)

7-AGE: 28 yrs. ..... mos. ..... ds.
If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedor
(b) General nature of industry, business, or establishment in which employed (or employer): 74

9-BIRTHPLACE, (State or Country): Poland

PARENTS.
10-NAME OF FATHER: Peter Kozlowski
11-BIRTHPLACE OF FATHER (State or Country): Poland
12-MAIDEN NAME OF MOTHER: Paulin Zyzlinskis
13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter Kozlowsky
(Address) 327 S Bond

15- OCT 24 1924
Filed ....., 191. J. E. Wilson Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22, (Day) 1924 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... (~~Jurors~~) ..... find that said deceased came to ~~his~~ death ~~(autopsy or~~ inquiry.) on the day stated above.
The CAUSE OF DEATH* was as follows:
Shock & internal Hemorrhage due to being Struck by a ball of Paper while loading Shells
(Duration) a few hours
CONTRIBUTORY (Secondary) As above
(Duration) ..... yrs. a few hours
(Signed) M. K. Grenet M. D.
(Coroner.)
10-B. 1924 (Address) 117 N Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary
DATE OF BURIAL, Oct 25 1924
20-UNDERTAKER Wm F Galloway
ADDRESS 1105 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58008

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 58008

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (NO. 8 Mary ave ST., 22 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frank. Wenmd Mettee

(Residence in Baltimore: No. 8 Mary Ave, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Married

6-DATE OF BIRTH, May 14 (Month) (Day), 1859 (Year)

7-AGE, 62 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Collector
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Lewis Mettee

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Susan Seamon

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Mettee

(Address) 8 Mary Ave

15- Robert P. Harrison,

Filed....., 191.....

OCT 24 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) H Donley M. D.
(Coroner)

(Address) 4 E Lex St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Md	Oct 25, 1921
20-UNDERTAKER	ADDRESS
H. J. Eschner Sons	North & Penna Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58009 ✓ D 58009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 20

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No.) ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lelia Price

(a) RESIDENCE. NO. 228 N. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (Husband of) (or) WIFE of: Edward Price

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 35 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bay View Hospital Baltimore, Md

15 Filed Oct 24 1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5 1921, to Oct. 23 1921, that I last saw h alive on Oct. 23 1921, and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia (Streptococcic) 0732

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Stomatitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Post. Mortem

(Signed) H. F. Dowsmith M. D.

10/24/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Oct 24 1921

20 UNDERTAKER: Chas. H. Weiss — ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had infected tooth which caused stomatitis. This in turn caused septicaemia.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58010

D 58010

CERTIFICATE OF DEATH.

REGISTERED NO. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 Fawcett ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Watts

(Residence in Baltimore: No. 409 Fawcett St.; yrs., mos. 1/2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 22, 1921 (Month) (Day) (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, 6 hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...0.0...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Travis Watts

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Bertha Virginia Fletcher

13-BIRTHPLACE OF MOTHER (State or Country), Fahear Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Watts

(Address) 409 Fawcett St.

15- Robert H Harrison,

Filed ... 191... 9 o'Clock ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1921, to Oct 22 1921, that I saw her alive on Oct 22 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

Haemorrhage Intra Uterine

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs...mos...ds.

(Signed) Roscoe Eltrom M. D.

Oct 23, 1921 (Address) 1435 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, ..., 191...

20-UNDERTAKER JOHNS HOPKINS HOSPITAL

ADDRESS

Commissioner Health. OCT 2 1921

WRITE PLAINLY, WITH UNFADING INK.

S.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

G 24 1921 Registrar

1853 Please call for additional.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58011

CERTIFICATE OF DEATH.

136 D 58011

REGISTERED NO.

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Lombard & Green ST.: 16 WARD)

2-FULL NAME Zilla Green

(a) RESIDENCE. NO. 1408 Riggs Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Green

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1/2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Baldon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) University Hospital Records

15 Filed Robert P. Harrison, Registrar

OCT 24 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1921, to Oct 21, 1921, that I last saw her alive on Oct 21, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Hemorrage (Uterine) & Surgical Shock

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ruptured Uterus Pregnancy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Oct 21st 21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. Morris Rose, M. D.

10-21 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 25 21

20 UNDERTAKER Daniel Ecclin

ADDRESS 976 Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58012

CERTIFICATE OF DEATH.

151 D 58012

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Gorsuch Ave ST., 9 WARD)

2-FULL NAME Helen Marie Cochran

(a) RESIDENCE NO. 908 Gorsuch Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24-1921

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William J Cochran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Grace Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: William J. Cochran
(Address): 908 Gorsuch

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

OCT 24 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1921, to 10/24, 1921, that I last saw h.r alive on 10-24, 1921, and that death occurred, on the date stated above, at 1158 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D W Bernardgreen M. D.

10 Oct. 1921 (Address) 914 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thos Long Green Md — DATE OF BURIAL 10/25 1921

20 UNDERTAKER: William Cook — ADDRESS 502 E North

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58013

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecil C. Gaither.

(Residence in Baltimore: No. 1716 N. Calvert St. St.: yrs., 5 mos. --- ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, January 19th. 1878., 1 (Month) (Day) (Year)

7-AGE, 47 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Electrician.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Q.V.

9-BIRTHPLACE, (State or Country). Gaithersburg Md.

PARENTS.

10-NAME OF FATHER, William R. Gaither.

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Jane M. Moore.

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanley D. Gaither. (brother)

(Address) Gaithersburg, Md.

15- Robert F. Harrison,

Filed....., 191..... Registrar.

Burial Permit Clerk.

OCT 24 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22nd. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the base of skull.
Accidental fall from a ladder.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....(Duration).....yrs.....mos.....ds.

(Signed) Chas. Leonhardt M. D. (Coroner.)

Oct. 24., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Accident Oct. 22nd. 1921 at the Sugar refinery

Former or usual residence..... Locust Point.

19-PLACE OF BURIAL OR REMOVAL, Gaithersburg Md. DATE OF BURIAL, 10-24, 1921

20-UNDERTAKER Chas. J. Bleck ADDRESS 742 W North Ave

D 58014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58014

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 808 W. North Ave WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Waldsachs

(Residence in Baltimore: No. 808 W. North Ave St.: 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Oct 25, 1853 (Month) (Day) (Year)

7-AGE: 66 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Joseph Weisenfay

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Fisher

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Husband Adelheim Waldsachs

(Address) 808 W. North Ave

15- Robert P. Harrison, ..., 191.....
Burial Permit Clerk. Registrar.

OCT 24 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, au- topsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Oct 24 1921 (Address) 3432 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mount Marie Cemetery, Towson

DATE OF BURIAL: Oct. 27, 1921

20-UNDERTAKER: Elmer W. Conklin

ADDRESS: 124 E. Eager St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58015 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58015

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr. Samuel Wiber Varner

(a) RESIDENCE. NO. Kingwood W. Va. ST., WARD. Kingwood W. Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 10, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Samuel W. Varner

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Katie C. Dartsche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed OCT 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to Oct 24, 1921, that I last saw him alive on Oct. 24, 1921, and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. 3 mos. + ds.

CONTRIBUTORY (Secondary) internal hydrocephalus

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? W. Va.

Did an operation precede death? yes Date of Oct 21, '21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Maud A. Reid, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 25 1921

20 UNDERTAKER ADDRESS

Wm C. Black 427 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58016 ✓

D 58016

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Francis ST., 13 WARD)

2-FULL NAME Mildred Maith

(a) RESIDENCE NO. 2601 Francis ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 - 1914

7 AGE — Years: 7 — Months: — Days: — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Madison Maith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Flonnie Dawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Madison Maith

(Address) 2601 Francis

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

C 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1921, to Oct. 23, 1921,

that I last saw her alive on Oct. 23, 1921, at 2.30 P m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): General Coll. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C Hamm M. D.

, 19 (Address) 1910 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's DATE OF BURIAL Oct 26 1921

20 UNDERTAKER: McMechen Co 16 ADDRESS 50 & Nott

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58017

D 58017

CERTIFICATE OF DEATH.

151 V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Rose ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bilz

(a) RESIDENCE. No. 407 N. Rose ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 27 Sept 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Bilz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Bunger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Edward Bilz
(Address) 407 N. Rose st.

15 Filed OCT 25 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to Oct 24, 1921, that I last saw him alive on Oct 22, 1921, and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Gastritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) A. C. & Deaver, M. D.

10/24, 1921 (Address) 2600 E. Balto. st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct. 25 1921

20 UNDERTAKER Jos. F. Ulm ADDRESS 156 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58018

D 58018

CERTIFICATE OF DEATH.

177

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Victoria Lutz

(a) RESIDENCE. No. 5006 Woodlawn Ave Ward. St. Anns
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Walter F. Lutz

6 DATE OF BIRTH (month, day, and year) July 2 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Francis Stroble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Walter F. Lutz

(Address) 5006 Woodlawn ave Razpsburg

15 Filed OCT 28 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1921, to Oct. 24, 1921, that I last saw h.e alive on Oct. 24, 1921, and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malignant Endocarditis and Septicemia (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Herman J. Dorf, M. D.

. 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct. 28 1921

20 UNDERTAKER Jos. J. Merr ADDRESS 156 N. Luzerne ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58019

D 58019

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 165 W. Henrietta ST.: 23 WARD)

2-FULL NAME Alice R. Bee

(a) RESIDENCE. No. 165 W. Henrietta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm Bee

6 DATE OF BIRTH (month, day, and year) [illegible] 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Providence R. I.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 [redacted]PLACE OF MOTHER (city or town) [redacted]r country) Unknown

14 Informant Geo Brown
(Address) 165 W. Henrietta St

15 Filed OCT 25 1921 [illegible] (Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th 1921, to Oct 22 1921, that I last saw h[illegible] alive on Oct. 22, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Hemorrhages

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) D. St. Lawrence, M. D.

10/24/1921 (Address) 140 N. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 25 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 112 W Hill St

N. B.—WRITE PLAINLY. WITH [illegible] be properly classified. AGE should be carefully supplied. AGE should be stated in years, months and days. Exact statement of information should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

Spec.—B 24 14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58020

CERTIFICATE OF DEATH.

28 ✓ D 58020

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 Lorman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W Seymour

(Residence in Baltimore: No. 1818 Lorman St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) 1 (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, David Seymour

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Jane Bibbins

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo. Seymour (wife)

(Address) 1818 Lorman St.

15-

Filed ..... 191.....

BURIAL PERMIT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct-15 1921, to Oct-22 1921, that I saw h[illegible] alive on Oct-22 1921, and that death occurred, on the date stated above, at 10-15 m.

The CAUSE OF DEATH* was as follows:

..... Pleuracy .....

..... (Duration) .....yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. ..... mos. ..... ds.

(Signed) T E Daugherty M. D.

Oct 22, 1921 (Address) 1662 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Oct. 24, 1921

20-UNDERTAKER James H. Dunn

ADDRESS 312 Fremont

N. B.—Every item of information should be carefully supplied. AGE should be correctly stated. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY.

ROBERT B. KRAUTH

OCT 25 1921

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58021

REGISTERED NO. 79 D 58021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Reservoir ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia N Brooks

(a) RESIDENCE NO. 611 Reservoir ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21 - 1912

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
9	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George F. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Brooks Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Bennet B Norris

(Address) 340 Dolphin St

15 Filed OCT 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3 , 1921 , to Oct 23 , 1921 ,

that I last saw h er alive on Oct 23 , 1921 ,

and that death occurred, on the date stated above, at 11 35 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis, Mitral stenosis & insufficiency, adherent pericardium

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) Myocarditis; acute and chronic

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P Hamburger, M. D.

Oct 24 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 25 1921

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58022 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 58022

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 W. Hennetta ST.: 73 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw. Buck

(a) RESIDENCE. No. 231 W. Hennetta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 11th 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Ordinary

(c) Name of employer Calvert Co Md

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Lloyd Buck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Emma Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md.

14 Informant Lloyd Buck (Address) 231 W. Hennetta St

15 Filed OCT 25 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8 1921 to Oct. 23 1921.

that I last saw him alive on Oct. 21 1921.

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis about 6 mos.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D H Carroll, M. D.

, 19 (Address) 140 W. Hall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cose Point Calvert Co Md	Oct 25 1921

20 UNDERTAKER R L Parham ADDRESS 679 W Lee St

N. B.—WRITE PLAINLY. WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of DATE OF BIRTH should be carefully supplied. AGE should be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 58023

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 58023

REGISTERED NO. C.....

1 PLACE OF DEATH 4144 Pimlico Rd.

CITY OF BALTIMORE: (No. Florence ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence H. Ziegfeld

(Residence in Baltimore: No. 4144 Pimlico Rd St.; 33 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M.

4-COLOR OR RACE: W.

5-SINGLE, ~~MARRIED, WIDOWED~~ OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: June (Month) 27 (Day), 1888 (Year)

7-AGE: 33 yrs 3 mos 26 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Photographer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Florenz E. Ziegfeld.

11-BIRTHPLACE OF FATHER (State or country): Ill.

12-MAIDEN NAME OF MOTHER: Mary Pope

13-BIRTHPLACE OF MOTHER (State or country): Ill.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev J. W. Peters

(Address) 444 Pimlico Road,

15- FILED OCT 25 1921 ..... 191.. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 10 (Month) - 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/19, 1921, to, 10/23 1921, that I saw h.im alive on 10/23 1921, and that death occurred, on the date stated above, at 12 m m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) ... yrs ... mos. 7 ds.

Contributory (SECONDARY) Exhausted heart

(Duration) ... yrs ... mos. ... ds.

(Signed), Hugh Russell M. D.

10/23, 1921. [Address] 3402 Groveland Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct 25, 1921

20-UNDERTAKER: George J. Arnold — ADDRESS: 1900 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. WRITE PLAINLY, WITH UNFADING INK. state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58024

CERTIFICATE OF DEATH.

120 D 58024

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Enos ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry James Shuett

(a) RESIDENCE. NO. 1306 Enos ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, ~~widowed~~, or divorced
HUSBAND of (or) WIFE of Minnie L Shuett

6 DATE OF BIRTH (month, day, and year) Dec. 30 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Distributing Company

(c) Name of employer Baltimore md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER J. Wesley Shuett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Minnie L Shuett
(Address) 1306 Enos st

15 Filed OCT 25 1921 ROBERT A KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1920, to Oct. 22, 1921, that I last saw him alive on Oct. 22, 1921, and that death occurred, on the date stated above, at 5:25 P. m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis, arteriosclerosis, chronic cystitis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Anemia
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) S. Lee Magness, M. D.

Oct 22 1921 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 25 1921
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—[illegible] PHYSICIAN'S [illegible] Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Finnick

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58025

D 58025

CERTIFICATE OF DEATH.

154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1540 Westhington ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Finnick

(a) RESIDENCE. No. 1540 Westhington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~M~~ F	W.	Widow

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Philip Finnick

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Hugh Welch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliz. J. Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Robt. H. Finnick
(Address) 1540 N. Westhington

15 Filed OCT 25 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 19, to Oct 24, 19 21,

that I last saw h~~e~~r alive on Oct 20, 19 21,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) Dr. O. Edwards M. D.

Oct 24, 1921 (Address) 928 N. Fortieth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Oct 27 1921
20 UNDERTAKER Henry Lutz	ADDRESS 203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58026 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 3912 Maine Ave (Street) Forrest Park (Ward)

REGISTERED NO. 41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick H Kehrenberg

(a) RESIDENCE. No. 3912 Maine Ave Forrest Park. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kehrenberg

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred. Kehrenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorst Rudie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Kehrenberg

(Address) 3912 Maine Ave Forrest Park

15 Filed OCT 25 1921 19.... ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 1920 to Oct 23 1921, that I last saw him alive on Oct 22 1921, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion due Malignous Cachexia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinomato of Prostate Gland Lymph Glands (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Asbury L Fetterolf, M. D.

1/24 1922 (Address) 806 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Cem Pikesville	Oct. 25th 1921
20 UNDERTAKER	ADDRESS
Mr. Mrs John W. Tewfel & Son	801 W. Fayette St.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58027

CERTIFICATE OF DEATH.

D 58027

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Railway Ave & Long Place ST.: Fairlawn WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Maxwell

(a) RESIDENCE. No Railway Ave & Long Place ST., Fairlawn WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? 44 yrs. 2 mos. 2 ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Wm H. Maxwell.

6 DATE OF BIRTH (month, day, and year) Oct 20/77

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Thomas Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma Shelus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Wm H. Maxwell
(Address) Railway Ave & Long Place

15 Date OCT 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22 1921

17 I HEREBY CERTIFY, That I attended deceased from September 10, 1921, to October 22, 1921, that I last saw her alive on October 22, 1921, and that death occurred, on the date stated above, at 4 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Throat.
(Secondary Metastasis to Necks Mediastinum)

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency Oedema Lungs - Exhaustion

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Section of Glands

(Signed) W. L. Keyser, M. D.

, 19 (Address) 54 N. Mielton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Oct 25 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY. All information should be carefully supplied. Age should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence must be given. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58028

CERTIFICATE OF DEATH.

D 58028
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 346 Forrest ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Black

(a) RESIDENCE. No. 346 Forrest ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Geo. F. Black

6 DATE OF BIRTH (month, day, and year) Dec 18 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Althelwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Geo. F. Black 346 Forrest St

15 Filed OCT 25 1921, 19 ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1921, to Oct 24, 1921, that I last saw h[illegible] alive on Oct 23, 1921, and that death occurred, on the date stated above, at 7:54 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia - Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles J Block, M. D.

, 19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Oct 27 '21
20 UNDERTAKER Philip Herwig	ADDRESS 206 Orleans

N. B.—WRITE PLAINLY. WITH ... mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58029

58029

CERTIFICATE OF DEATH.

104 D 58029

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Bryant ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anita H Smith

(Residence in Baltimore: No. 2016 Bryant St.: ....yrs., 8 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Feb. (Month) 12. (Day), 1921 (Year)

7-AGE, ...yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Melvin Smith

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Estaddes Bonnaij

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melvin Smith

(Address) 2016 Bryant St

15- OCT 25 1921 Filed....., 191.... ROBERT A. KRANTZ Registrar.

Baltimore Health Dept.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1921, to Oct 23 1921, that I saw her alive on Oct 22 1921, and that death occurred, on the date stated above, at 8.25 p. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Intestinal Dyspepsia

(Duration) ....yrs. 2 mos. 2 ds.

(Signed) J. Lamb Steinort M. D.

10-25, 191... (Address) 704 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Auburn Cem DATE OF BURIAL, Oct 26, 1921

20-UNDERTAKER Samuel Hensley ADDRESS Baltimore

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58030

CERTIFICATE OF DEATH.

37-091

37 D 58030

REGISTERED NO.....

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE: No. ..... ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Sheely

(a) RESIDENCE. No. 3136 Hudson ST., / WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Sheely

6 DATE OF BIRTH (month, day, and year): Feb 9th 1886

7 AGE: Years 35. Months ... Days ... If LESS than 1 day, hrs. or min. ...

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: [illegible] Sheely

11 BIRTHPLACE OF FATHER (city or town) (State or country): U.S.

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible] U.S.

14 Informant (Address): Boy View Hospital Balto Md.

15 Filed OCT 25 1921 . 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1920 to Oct. 22 1921, that I last saw him alive on Oct. 22 1921, and that death occurred, on the date stated above, at 10.00 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

CONTRIBUTORY (Secondary): General Paresis (duration) ... yrs. ... mos. ... ds.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) H. McDonough M. D.

10/23/21 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Oct 26 1921

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S Wolfe St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of DATE OF BIRTH and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Paresis lactis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58031

CERTIFICATE OF DEATH.

92 D 58031

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 S Strathmore Ave. ST.: 27 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Baummer.

(a) RESIDENCE. No. 17 S Strathmore Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth C Baummer.

6 DATE OF BIRTH (month, day, and year) Nov. 3- 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Associate member of

(b) General nature of industry, business, or establishment in which employed (or employer): Mary-Donnelly-

(c) Name of employer: Williams Co. Inc.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Sigmund Baummer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Geraldine Siebert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Elizabeth C. Baummer. 17 S Strathmore Ave

15 Filed OCT 25 1921 ROBERT J. BRAUTIGAM Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to Oct 23, 1921, that I last saw h[illegible] alive on Oct 23, 1921, and that death occurred, on the date stated above, at 3.15A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? [illegible] Date of

Was there an autopsy? [illegible]

What test confirmed diagnosis?

(Signed) A. F. Powers, M. D.

, 19 (Address) 921 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct. 26 1921
20 UNDERTAKER	ADDRESS
Tilly & Fiske	403 S. Wolfe

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. OCCUPATION should be stated. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58032

D 58032

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 S Bond St ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo P Falkenhan

(a) RESIDENCE. No. 829 S. Bond ST. 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 14y. yrs. — mos. — ds. How long in U. S., if of foreign birth? 14y. yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Child

6 DATE OF BIRTH (month, day, and year) Aug 24-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Casper Falkenhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherin Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Casper Falkenhan
(Address) 829 S Bond St

15 OCT 25 1921 ROBERT A KRAUSER Registrar

Burial Permit Issued

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1921, to Oct 24, 1921, that I last saw him alive on October 24, 1921, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Mucous Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical symptoms

(Signed) Samuel A'Cohen, M. D.

, 19 (Address) 22 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt Carmel Cem — DATE OF BURIAL Oct 25 1921

20 UNDERTAKER Stephen Kralkowski — ADDRESS 1008 S Paca St

Portia Fechtig

58033 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 58033

136

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Breeden Hellmans Hosp ST.. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Portia Fechtig

(a) RESIDENCE. NO. 1218 Battery Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Orin S. Fechtig

6 DATE OF BIRTH (month, day, and year) July 27, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lewis Harbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Orin S. Fechtig

(Address) 1218 Battery Ave

15 Filed OCT 25 1921 19 ROBERT J. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/14/21, 19..., to 10/22, 19 21, that I last saw her alive on 10/22/21, 19..., and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Curettment 5 weeks after delivery of hydatid mole (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/22/21

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) O.B. Towles, M. D.

10/23, 1921 (Address) 142 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a&B	10-25 1921
20 UNDERTAKER E & B Hasle	ADDRESS 115 E West St

N. B.—WHITE PAPER should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be properly classified. Exact information

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58034

CERTIFICATE OF DEATH. X 1-8917

D 58034

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: No. Lombard and Green ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ruth R. Ireland

(a) RESIDENCE. NO. 2716 Harpder ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~Husband~~ of (or) WIFE of Roy Ireland

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys County

PARENTS

10 NAME OF FATHER Chas E. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co. Md.

12 MAIDEN NAME OF MOTHER Estelle Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co. Md.

14 Informant Hospital Records.

(Address)

15 Filed . 19 Registrar

OCT 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 24 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1921, to 10-24, 1921, that I last saw her alive on 10-23, 1921 and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 54 ds.

CONTRIBUTORY (Secondary) Bronchio - Pneumonia

x Toxemia (duration) yrs. mos. 54 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood exam.

(Signed) F. A. Holden, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holland Point Md.	Oct 25 21
20 UNDERTAKER	ADDRESS
A. L. Marshall	3539 Fall Rd

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact information may be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Sies

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58035

CERTIFICATE OF DEATH.

91 D 58035

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3321 Chestnut Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline J. Sies.

(Residence in Baltimore: No. 3321 Chestnut Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word.) Married

6-DATE OF BIRTH, November 13, 1845
(Month) (Day) (Year)

7-AGE, 76 yrs. 11 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Occupation
(b) General nature of industry, business, or establishment in which employed (or employer) .....

D37

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, George Fitz

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co

12-MAIDEN NAME OF MOTHER Harriet Haines

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Sies

(Address) 3321 Chestnut Ave

15- ROBERT J. BRAUER
Registrar.

Filed ....., 191.... Deputy Registrar.

OCT 25 1921

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 23rd, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1921, to Oct 23 1921, that I saw her alive on Oct 22 1921, and that death occurred, on the date stated above, at 2 AM

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) A Shelley M. D.

Oct 23 1921 (Address) 3849 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Oct 25, 1921

20-UNDERTAKER R. S. Marsh ADDRESS 353 Fall Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58036

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Anna Klein

(a) RESIDENCE. No. Hebrew Hospital, E Monument ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Hebrew Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Baral Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gurbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J Levis 1411 E Balto St

15 [illegible] OCT 25 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1921, to Oct 24, 1921, that I last saw her alive on Oct 24, 1921, and that death occurred, on the date stated above, at 5-15 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

2 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exophthalmic Goitre

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 24, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

Oct 24, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen circle Mt Carmel	10/25 1921
20 UNDERTAKER	ADDRESS
Jack Levis	1411 E Balto

N. B.—WRITE PLAINLY. WHERE [illegible] should be properly classified. AGE should be carefully supplied. All information should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Last birthday and CAUSE OF DEATH is very important. See instructions on back of certificates. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58037 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓138 D 58037

CERTIFICATE OF DEATH. REGISTERED NO.

1-PLACE OF DEATH Patient died at St. Joseph's Hospt

CITY OF BALTIMORE: (No 636 East 36th St.; 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma C Werner

(a) RESIDENCE. NO. 636 E. 36th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced (or) WIFE of John A. Werner

6 DATE OF BIRTH (month, day, and year) Oct 8, 1878

7 AGE Years 43 | Months | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED At home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant (Address) John A. Werner 636 East 36th St

15 Filed OCT 25 1921 ROBERT E. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-24-21, 19..., to 10-24, 1921, that I last saw her alive on 10-24, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia ANTEN

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-24-21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D. Conte Jr. M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland

DATE OF BURIAL Oct 28 1921

20 UNDERTAKER Firkler & Firkler

ADDRESS 1739 Eager

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. 21

Form 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58038

D 58038

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: No. 2513 Fait ave ST.: 1 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lind Jr.

(a) RESIDENCE. No. 2513 Fait ave. Balto ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Alma Lind -

6 DATE OF BIRTH (month, day, and year) Jan. 10- 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto -

PARENTS

10 NAME OF FATHER Henry Lind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto -

12 MAIDEN NAME OF MOTHER Eliz. Bahm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto -

14 Informant (Address) University Hospital

15 Filed OCT 25 1921 ROBERT J. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-21-21, 1921, to 10-23, 192, that I last saw him alive on 10-23, 1921, and that death occurred, on the date stated above, at 12-15 A m.

The CAUSE OF DEATH* was as follows:

Acute Encephalo Myelitis -

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no -

What test confirmed diagnosis? Clinical -

(Signed) F A Holden, M. D.

, 19 (Address) University Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Oct 28 1921
20 UNDERTAKER Pikler & Pikler	ADDRESS 1739 Eager

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back

(Rehrer)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58039

CERTIFICATE OF DEATH.

64 D 58039
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. in Hospital 3800 Block Eastern Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Rehrer

(Residence in Baltimore: No. 3950 Dillon St.: yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widowed

6-DATE OF BIRTH, Oct 18 (Month) (Day), 1853 (Year)

7-AGE, 68 yrs. mos. ds.
If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiterman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Rehrer Sr

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Burke

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Rehrer

(Address) 3950 Dillon

15- Filed OCT 25 1921 ROBERT J. KRAUTH Registrar. Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Thomas Ryan M. D. (Coroner)

Oct 25, 1921 (Address) 1802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland — DATE OF BURIAL, Oct 27, 1921

20-UNDERTAKER Fickler & Pickler — ADDRESS 1739 Eager

N. B.—Every item of information should be carefully supplied. All CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 58040

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 58040

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 906 N Clinton ST. No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche M White

(Residence in Baltimore: No. 906 N Clinton St St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Oct 22, (Month) (Day) 1844 (Year)

7-AGE, 77 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Louis Cain

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Elizabeth Chappell

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie E Dunlap

(Address) 906 N Clinton St

15- Filed OCT 25 1921 191.... [illegible] Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Theus Mc Donald, M. D. (Coroner)

Oct 25, 1921 (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Oct 26, 1921
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1737 Eager

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58041

CERTIFICATE OF DEATH

18 VD 58041

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Williams

(Residence in Baltimore: No. 929 N Chapel St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer 04

9-BIRTHPLACE, (State or Country), born in Baltimore City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Hughes

13-BIRTHPLACE OF MOTHER (State or Country), S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bessie Williams
(Address) 929 N Chaffel St

15- OCT 25 1921 ROBERT J KRAUTER
Filed ..... 191... Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Homicide by pistol shot
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mon. ..... ds.
(Signed) H A Gudley M. D.
(Coroner)
Oct 23, 1921... (Address) 926 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Oct 26, 1921.

20-UNDERTAKER Mrs Robert A Elliott — ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Martha Distance

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58042

CERTIFICATE OF DEATH.

64 D 58042

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 807 Ashland Ave ST.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Distance

(Residence in Baltimore: No. 807 Ashland Ave St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1855 (Year)

7-AGE 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... House Work

9-BIRTHPLACE, (State or Country) live in Balt- 40 years Cambridge Md

PARENTS.

10-NAME OF FATHER, Thomas Hicks

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co Md

12-MAIDEN NAME OF MOTHER Martha J Hicks

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Gragg

(Address) 807 Ashland Ave

15- OCT 25 1921 Filed ....., 191.... ROBERT I KRAUTH Registrar.

Burial Permit Issued

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 9 (Month) 22 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemiplegia prob.

Cerebral Hemorrhage (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, [redacted] Cemetery — DATE OF BURIAL, Oct 30, 1921

20-UNDERTAKER Wm R A Elliott — ADDRESS 1725 Ashland Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58043

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

55-601 D 58043

REGISTERED No.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Gantt

(a) RESIDENCE. No. 1215 Rayborg St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40-50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

887

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) New City Hospital.

OCT 25 1921 [illegible] REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 20 1921. to October 22 1921. that I last saw him alive on October 22, 1921. and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Capt. Mueller, M. D.

10/22/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 25 1921
20 UNDERTAKER	ADDRESS 1140 W
Brown & Friedman & Schuster	

N. B.—This information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Guerin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58044

CERTIFICATE OF DEATH.

120 D 58044

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Beaumont Ave ST.: 27 WARD)

2-FULL NAME John F. Guerin

(a) RESIDENCE. NO. 509 Beaumont Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Guerin

6 DATE OF BIRTH (month, day, and year) June 24 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traffic Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) P. R. R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mathew Guerin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thos P. Guerin

(Address) 509 Beaumont Ave

15 Filed OCT 25 1921 ROBERT J. KRANTZ

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Oct 24 1921,

that I last saw him alive on Oct. 23 1921,

and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Oedema & Chronic Diarrhea

(duration) 6 months yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jefferies Buck, M. D.

Oct 24 1921 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Oct 27 1921

20 UNDERTAKER H. C. Windfeld — ADDRESS 914 Gruman Ave

mation should be carefully supplied. Blanks CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on b

Spec.—6-9-19—H. P. Co.—1000 Bks.

Loran Harrington

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58045

CERTIFICATE OF DEATH.

28

D 58045

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Loran Harrington

(a) RESIDENCE. No. 1 N. Va. Ave. Arlington Md. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mrs Mamie Harrington

6 DATE OF BIRTH (month, day, and year) March 26 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. M9

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alfred Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Josephine Dickson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md.

14 Informant Mamie Harrington (Address) Arlington Md.

15 Filed OCT 25 1921 19 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1921 to Oct 24, 1921

that I last saw him alive on Oct 24, 1921

and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Autopsy Date of Oct 19, 1921

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Symptoms

(Signed) John L Elson M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Ridge Cem	Oct 26, 1921

20 UNDERTAKER W. C. Hudefeld ADDRESS 914 Greenmount Av

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Form 6.0.13—H. P. Co.—1000 Blks.

D 58046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58046

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 N Hamby ST.: 21 WARD)

2-FULL NAME Margaret M. Eason

(a) RESIDENCE. NO. 745 N Hamby ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Walter J Eason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Minnie Pauls

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Walter J Eason
(Address) 745 N Hamby

15 OCT 25 1921 ROBERT J KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1921, to Oct 26, 1921, that I last saw h[illegible] alive on Oct 26, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Clinically

What test confirmed diagnosis?

(Signed) R E Lamport M. D.

Oct 25, 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cath	10-26 1921
20 UNDERTAKER	ADDRESS
E & B Slade	115 E West St

A. B. C. matters should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information should be properly classified. Exact statement of OCCUPATION may be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58047

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D 58047

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 623 W. Lafayette Av St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Elizabeth Snyder,

(Residence in Baltimore: No. 623 W. Lafayette Av St.; abt 80 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6-DATE OF BIRTH April 13, 1850
(Month) (Day) (Year)

7-AGE 71 yrs. 6 mos. 10 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: not known

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: not known

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Andrew Snyder

(Address) 623 W Lafayette Ave

15- OCT 25 1921 ROBERT J KRAUTER Burial Permit Clerk REGISTRAR

N. B.—Every item of information should be carefully supplied. Exact statements should be made, so that it may be properly classified. Exact statements should be made, so that it may be properly classified. In state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements should be made, so that it may be properly classified. TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH October 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to, Oct 23, 1921, that I saw h.. alive on Oct 23, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis, with general Arteriosclerosis.

unknown (Duration) yrs mos. ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis

unknown (Duration) yrs mos. ds.

(Signed) Charles Gelb M. D. M. D.

Oct 23, 1921. [Address] 1111 W Lanvale St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: 10-26, 1921

20-UNDERTAKER: Mrs Chas A Gohde — ADDRESS: 600 N. Arlington Ave.

Spec.-1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58048

CERTIFICATE OF DEATH.

79 D 58048

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 671 W. Fayette ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Russell

(a) RESIDENCE NO. 671 W. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —— 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ?

PARENTS

10 NAME OF FATHER: Moses Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Hannah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Jack Lewis (Address) 1411 E Baltimore St

15 OCT 25 1921 ROBERT J. BRAGER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1921, to Oct 23, 1921, that I last saw him alive on Oct 23, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilitation (Cardiac)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

Oct 25 1921 (Address) 2687 Wiekens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bath Hebrew Cem — DATE OF BURIAL 10/26/1921

20 UNDERTAKER: Jack Lewis — ADDRESS 1411 E Baltimore St

N. B.—WRITE mation should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58049 ✓ 92 D 58049

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 Appleton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Carroll.

(Residence in Baltimore: No. 1644 Appleton St.; 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, ? (Month) ? (Day) 1860 (Year)

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Henry O. Carroll

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary A Stoneback

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa L. Scott

(Address) 1644 N. Monroe St.

15- Filed Oct 25 1921, 191.

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17 1921, to Oct 25 1921, that I saw h-r alive on Oct 24 1921, and that death occurred, on the date stated above, at 2.40 p. m.

The CAUSE OF DEATH* was as follows:

Solar Tuberculosis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Irvin Eberly M. D.

Oct. 25, 1921 (Address) 710 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Oct. 27, 1921.

20-UNDERTAKER Weston Fahey & Sons ADDRESS 1827 W. Fayette St.

Every item of information must be properly examined, so that it may be CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

N

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58050

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Hanover St.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Watson

(a) RESIDENCE. NO. 8 N Hanover St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 79 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) 9/12/1842

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	79	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Thomas Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

11 Informant John Watson
(Address) #8 N. Hanover St.

15 Filed CT 25 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 1921 to Oct 22 1921.

that I last saw he alive on Oct 22 1921.

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Hart Insley M. D.

10-25-21 (Address) 2958 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cemetery	10/26/21
20 UNDERTAKER	ADDRESS
Geo J. Ruth	1135 Harford Ave

B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be properly classified. Exact statement that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 58051

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 150

D 58051

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Kumstetter

(a) RESIDENCE. No. Terrehaute, Indianna ST.. WARD. Terre Haute Ind,

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-18-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indianna

PARENTS

10 NAME OF FATHER Russell E. Kumstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indianna

12 MAIDEN NAME OF MOTHER Lola Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indianna

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed OCT 25 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY. Words should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be properly classified. Exact information

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 58052 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58052

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Nursery & Childs Hosp. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Markinowski

(a) RESIDENCE. NO. Franklin & Schroeder St WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank Marcinkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Frank Marcinkowski 1606 Jenough St

15 Filed . 19 Registrar

OCT 27 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1920, to Oct 25, 1921, that I last saw him alive on Oct 25th, 1921, and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxiation caused by necrosis ulcer of nares (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Brad H. Pierce Jr. M. D.

10/25, 1921 (Address) 1902 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 27 1921

20 UNDERTAKER ADDRESS

John McWeber 1803 Bank

B.—WRITE PLAINLY with pen and ink. Information should be carefully supplied. AGE should be properly classified. Exact information is required. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates. See instructions on back of certificates. See instructions on back of certificates. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58053

CERTIFICATE OF DEATH.

64

D 58053

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 36 WARD)

2-FULL NAME Charles E. Gamble

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed Robert P. Harrison, Registrar
OCT 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23 19 21

17 I HEREBY CERTIFY, That I attended deceased from October 21. 19 21. to October 23. 19 21. that I last saw h.. im alive on October 23. 19 21. and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (?)
Death sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

10-25-1921 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Second Presbyterian Cemetery	Oct 26 1921
20 UNDERTAKER	ADDRESS
Wm Johnson & Sons	700 Asquith St

N. B.—WRITE PLAINLY. All information should be carefully supplied. Any mistake may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 58054 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58054

CERTIFICATE OF DEATH.

H 2

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Becker

(a) RESIDENCE. No. 2704 Garrison Blvd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Rochester, New York.

PARENTS

10 NAME OF FATHER: Fred Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothy Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Catonsville, Maryland

11 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed CT 25 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1921 to October 24 1921 that I last saw her alive on October 24, 1921 and that death occurred, on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Secondary Anemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of August 20, 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. E. Broadrup, M. D.

10/25/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Oct 27 1921
20 UNDERTAKER	ADDRESS
Wm J Ruckert & Sons	North Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. After CAUSE OF DEATH in plain terms, so that it may be properly classified. Particular attention is very important. See instructions on back of certificates.

(Mewshaw) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58055

D 58055

99

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 16 WARD)

2-FULL NAME Anna Ruth Newshaw

(a) RESIDENCE. NO. 3107 Presbury ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) apl 29 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER A. J. Newshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ruth Newshaw (Address) 3107 Presbury St.

15 Filed Robert P. Harrison, Registrar

OCT 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1921, to Oct 24, 1921, that I last saw her alive on Oct 24, 1921, and that death occurred, on the date stated above, at 11.20 p m.

The CAUSE OF DEATH* was as follows:

(Ulcerative abscess of left ovary

(Streptococcic - cardiac

(decompensation

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Left ovarian streptococcic cardiac decompensation (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 3107 Presbury St

Did an operation precede death? yes Date of 10/20/21

Was there an autopsy? no

What test confirmed diagnosis? clinical & Laparotomy findings

(Signed) Wm. D. Douglas, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct 27 1921

20 UNDERTAKER M. Turnbull & Sons

ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. EVERY ITEM MUST BE STATED EXACTLY. PHYSICIANS' ATTENTION is called to the fact that every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CERTIFICATE of CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58056

CERTIFICATE OF DEATH.

D 58056

REGISTERED NO. 9v

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 924 N Dunham ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Cummings

(a) RESIDENCE. NO. 924 N Dunham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER Albert Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER Frances Kerba

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant Mrs Frances Kerba (Address) 924 N Dunham

15 OCT 26 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1921, to Oct 25 1921, that I last saw h[illegible] alive on Oct 25 1921, and that death occurred, on the date stated above, at 9 00 a. m.

The CAUSE OF DEATH* was as follows:

Cystitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilhelm D. Stamen, M. D.

Oct 25 1921 (Address) 501 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 26 1921

20 UNDERTAKER: Enoch Enoch & Son — ADDRESS: 1806 Eutaw

N. B.—WRITE PLAINLY. All items must be carefully supplied. Any information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 58057

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. D 58057

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2508 Ellamont St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Katherine B. Horton.

(Residence in Baltimore: No. 2508 Ellamont St.: 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH Sept. (Month) 20 (Day), 1838 (Year)

7 AGE 83 yrs. 1 mos. 3 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Cecil Co Md.

PARENTS

10 NAME OF FATHER: Jesse Horton

11 BIRTHPLACE OF FATHER (State or country): Cecil Co Md

12 MAIDEN NAME OF MOTHER: Catherine B. Mathews

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry M. Leary

(Address) 2508 Ellamont Ave

15 OCT 26 1921 (Date) 191

ROBERT J. BRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 24 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept — 1920, to Oct. 24 1921.

that I saw her alive on Oct. 22 1921.

and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (mitral regurgitation)

Indefinite (Duration) — yrs. — mos. — ds

Contributory (SECONDARY) Indefinite (Duration) — yrs. — mos. — ds.

(Signed) H. H. Arthur M. D.

Oct 24 21 (Address) 1426 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount — DATE OF BURIAL: Oct 26, 1921

20 UNDERTAKER: John Whitehill — ADDRESS: 1201 W. Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PRESENT OCCUPATION should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY

D 58058 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58058

CERTIFICATE OF DEATH. X 159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1111 Royal & Calvert st. or Street 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M Gillen

(Residence in Baltimore: No. Harford Co. Md St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Aug 27, 1853
(Month) (Day) (Year)

7-AGE. 68 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired 073
(b) General nature of industry, business, or establishment in which employed (or employer). R.R. Conductor

9-BIRTHPLACE, (State or Country). Bute Co. Md

PARENTS.

10-NAME OF FATHER. Dent Gillen

11-BIRTHPLACE OF FATHER (State or Country). Dent Gillen

12-MAIDEN NAME OF MOTHER. Charlotte Gillen

13-BIRTHPLACE OF MOTHER (State or Country). Harford Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mina Gillen

(Address) 522 S Washington St

15- Filed OCT 26 1921 ROBERT J. CRAWFORD Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide by pistol shot wound in brain

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. E. T. Price (Coroner.) M. D.

Oct. 26, 1921. (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Harford Co.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 10 26 21

20-UNDERTAKER Chas S. Cowe & Son ADDRESS 1111 Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Bell Fax

D 58059 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58059

CERTIFICATE OF DEATH.

REGISTERED NO. C 78

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 831 Raborg st ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bell Fax

(Residence in Baltimore: No. 831 Raborg st, St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Color

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct (Month) 29 (Day), 1874 (Year)

7-AGE, 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Launderess
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Chas Fax

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Belle Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. Jones

(Address) 735 Eidelman St

15- OCT 26 1921 191.. ROBERT J. CRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Don't Know!

(Duration) yrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

Oct 25, 1921 (Address) 117 W Hardy St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 26 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penna ave

N. B.—Every item of information should be carefully supplied. Age must be given. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—R. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

69 D 58060

CERTIFICATE OF DEATH.

REGISTERED NO.

D 58060
1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No 236 Pearl ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Skelpshias

(a) RESIDENCE. NO. 236 Pearl ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) off
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Skelpshias

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Antanina Zangeliute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Joseph Skelpshias Sr.
(Address) 236 Pearl St.

15 OCT 26 1921 ROBERT I. CARTER Registrar
Burial ... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to Oct. 24, 1921, that I last saw him alive on Oct 24, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Status epilepticus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) John a Buchness, M. D.

, 19 (Address) 650 Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct. 27 1921

20 UNDERTAKER: John Grebliauckas — ADDRESS: 425 S Bond

mation should be carefully answered, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58061

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH Robt Garrett Hosp for Children REGISTERED NO.....

CITY OF BALTIMORE: (NO. 27 N Carey ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathrene M Franklin

(a) RESIDENCE. NO. 51 Spring Row ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Apl 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) too
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Benjamin J Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie M Bauernschub

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant B J Franklin
(Address) 51 Spring Row

Filed OCT 26 1921 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 In Hosp Sept 24 - Oct 13th previous

I HEREBY CERTIFY, That I attended deceased from Oct 23rd, 1921, to Oct 27, 1921,

that I last saw her alive on Oct 23, 1921,

and that death occurred, on the date stated above, at 5.10 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Rachitis & Marasmus

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. Clift, M. D.

Oct 27 1921 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 26 1921
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut ave

mation should be carefully written in ink, preferably typewritten, and properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 58062

D 58062

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Walsh

(a) RESIDENCE. No. 404 St. Paul St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or min.
	55	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed OCT 26 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 21. 1921. to October 24. 1921. that I last saw her alive on October 23, 1921, and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bay View

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde A. Hill, M. D.

(Address) Municipal Hospital. 10/24/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 26 1921

20 UNDERTAKER ADDRESS

Chenowith & Son 261 E. Chestnut Ave

mation should be carefully answered, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58063

D 58063 CERTIFICATE OF DEATH.

REGISTERED NO. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Heaps.

(a) RESIDENCE NO. 5 N. Exeter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Clarence Rhyner

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna Heaps

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Pa.

14 Informant (Address) Johns Hopkins Hospital Record

15 OCT 26 1921 ROBERT J. BAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1921, to Oct. 21, 1921, that I last saw h/m alive on Oct 21, 1921, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) H. Cathcall, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL OCT 22 1921

Commissioner Health.

per. Wm. E. Woodall

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58064

CERTIFICATE OF DEATH.

19 D 58064

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 15th Division St., Balto, Md ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Francis Holton

(a) RESIDENCE. NO. 6006 Henderson Ave. ST.. .. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed,

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 089

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant August Pfeifer.

(Address) 40 Water Dept. Charles & Fayette

15 Filed OCT 26 1921 H. Wilms Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to Oct. 25, 1921, that I last saw h'm alive on Oct. 25, 1921, and that death occurred, on the date stated above, at 8 12 A m.

The CAUSE OF DEATH* was as follows:

Cardio - renal syndrome

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 6006 Henderson Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George E. W. Hardy M. D.

19 (Address) Union Memorial Hospital

O.K. by Coroner Hesse

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Oct 28 1921

ADDRESS

20 UNDERTAKER William Cook 002 E North Ave

mation should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Form —6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 58065

D 58065

CERTIFICATE OF DEATH.

X 138

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen. Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Regina Fairall

(a) RESIDENCE. NO. Academy Junction Motor ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman C. Fairall

6 DATE OF BIRTH (month, day, and year) Dec. 20 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Sapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Daisy Phelps

(Address) 1922 W. Lanvale St.

15 Filed OCT 26 1921 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Oct 25 1921, that I last saw her alive on Oct 25 1921, and that death occurred, on the date stated above, at 10 55 a m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

OVER

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George C Shannon M. D.

, 19 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethel A.A.C. Md	Oct 27 1921

20 UNDERTAKER William Cook. ADDRESS 502 E North

TION is very important. See instructions on back of cer

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

O.K.'d by Coroner Hennissey
Puerperal

D 58066 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

K 155 D 58066
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 215 N. Frederick ST. 4 WARD)
2-FULL NAME James Dougherty
(Residence in Baltimore: No.) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) ?
6-DATE OF BIRTH, ..., ..., 1 .....
(Month) (Day) (Year)
7-AGE, About 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work Ex Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) ?
9-BIRTHPLACE, (State or Country). Poland
PARENTS:
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country). Poland
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country). Poland
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Dougherty
(Address) Jersey City, N.J.
15- FILED OCT 26 1927 ROBERT E. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 9, 1927
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide by Carbolic Acid
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. N. Biles M. D.
(Coroner.)
Oct 20, 1927 (Address) 1059 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn
DATE OF BURIAL, Oct 28 1927
20-UNDERTAKER
ADDRESS 501 E 25th St Mt Carmel

N. B.—Every item of information should be carefully supplied. AGE must be given. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Burial Permit

58067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

MD 58067
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1413 S Cary ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Smith

(Residence in Baltimore: No. 1413 S Cary St

St 68 yrs. 11 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Femal	White	Widow

6-DATE OF BIRTH. Nov (Month) 9 (Day), 1854 (Year)

7-AGE. 66 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balt city

PARENTS.

10-NAME OF FATHER, William Dehn

11-BIRTHPLACE OF FATHER (State or Country), Balt city

12-MAIDEN NAME OF MOTHER Glazier

13-BIRTHPLACE OF MOTHER (State or Country), Balt city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Hoey

(Address) 1413 S Cary St

15-OCT 26 1921 ROBERT J. KRAUTH

Filed....., 191.... Burial Permit Clerk
Registrar.

N.B.—Every item of information should be entered, so that it may be properly classified. Date of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of 3 Rib & falling down Stairs, accident

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Traumatic Pneumonia

(Duration)....yrs....mos. 2 ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Oct 27 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery | DATE OF BURIAL, Oct 26, 1921

20-UNDERTAKER Joseph B. Cook | ADDRESS 1003 N. Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58068

CERTIFICATE OF DEATH.

130 D 58068

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1605 N. Bradford ST., 8 WARD)

2-FULL NAME Rosa Hinkle

(a) RESIDENCE NO. 1605 N. Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., If of foreign birth? 71 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Jacob Hinkle

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Heffner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. George Hinkle

(Address) 1605 N. Bradford St

15 OCT 26 1921 100 ROBERT J. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to Oct. 26, 1921.

that I last saw h[illegible] alive on Oct. 25, 1921

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. Fe Magnesso, M. D.

Oct 25, 1921 (Address) 1206 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 28 1921
20 UNDERTAKER Henry Hoerl Son	ADDRESS 1301 E Eager St.

mation should be carefully supplied. Entries may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Cox

D 58069 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58069

150

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 853 Powers ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Cox Jr

(a) RESIDENCE. NO. 853 Powers ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Singl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct 19 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	0	5	

8 OCCUPATION OF DECEASED ✓ 990

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John A. Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Stoffegen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Cox (Address) 853 Powers St

15 Filed OCT 26 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1921, to Oct 25, 1921, that I last saw h[im] alive on Oct 25, 1921, and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Debility, Foods not Assimilated

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Fair M. D.

, 19 (Address) 12 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL Oct 27 1921

20 UNDERTAKER Chenowith & Son ADDRESS Chestnut Ave

Burial Permit Given

Instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See

Spec. 6-9-19—H. P. Co.—1000 Bks.

Sarah Leidenroth

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58070

D 58070

CERTIFICATE OF DEATH.

REGISTERED NO. 134

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: NO. N. Broadway ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Leidenroth

(a) RESIDENCE. NO. 2306 Garrison ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Edmund A Leidenroth

6 DATE OF BIRTH (month, day, and year): Aug 12 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: D. G. Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Georgia Emma Fleet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Edmund A Leidenroth
(Address): 2306 Garrison ave

15 FILED: OCT 26 1921 ROBERT J KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1921, to Oct 25, 1921, that I last saw her alive on Oct 25, 1921, and that death occurred, on the date stated above, at 7 15 a m.

The CAUSE OF DEATH* was as follows:

Extra abdominal hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tubal Pregnancy, ruptured, left (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 25/21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Hobbs M. D.

, 19 (Address) Church Home & Hy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	10-28 1921
20 UNDERTAKER: Henry J Jenkins Sons Co	ADDRESS: W Cylbert Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Use no abbreviations or initials. Do not report symptoms or modes of dying, but the diseases or injuries which caused death. Additional space is provided on back of certificates. See instructions on back of certificates. This information is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Julia Dowman

(a) RESIDENCE. No. 118 Linwood Avenue ST., Atlanta, Georgia.
(Usual place of abode) WARD.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Scotland~~ Florida
(State or country)

PARENTS

10 NAME OF FATHER Mr. Wm. M. Dowman

11 BIRTHPLACE OF FATHER (city or town) Scotland
(State or country)

12 MAIDEN NAME OF MOTHER Miss Julia Welch

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Dr. Charles E. Dowman
(Address) Atlanta Georgia

15 Filed OCT 26 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26 1921

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1921, to October 26, 1921, that I last saw her alive on October 26, 1921, and that death occurred, on the date stated above, at 1:48 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach -

(duration) yrs. 9 (?) mos. ds.

CONTRIBUTORY (Secondary) Obstruction - peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Atlanta, Georgia

Did an operation precede death? Yes Date of Oct 13, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical

(Signed) George E. W. Hardy, M. D.

(Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Atlanta Georgia Oct 26 1921

UNDERTAKER — ADDRESS

John O. Mitchell 170 Decatur

CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Rumsey 812 Park ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58072

CERTIFICATE OF DEATH.

108 D 58072

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1 Bidler & Dellenbaugh ST., WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie M. Stirwin

(a) RESIDENCE NO. 912 E. Preston ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward Stirwin

6 DATE OF BIRTH (month, day, and year) July 8-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chestertown Md

PARENTS
10 NAME OF FATHER: William Norris
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Mary Walraven
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

14 Informant (Address): Edward E. Stirwin 912 E. Preston

15 Filed CT 26 1921, 19.....
Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1921

17
I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Oct 25, 1921,
that I last saw her alive on Oct 25 1921,
and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:
Chronic Appendicitis History acute exacerbations & frequent attacks operation Aug 9/21. Operation Oct 7/21 for leakage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death? Yes Date of Oct 7 21
Was there an autopsy? No
What test confirmed diagnosis? Surgical Operation
(Signed) Chas. Leland Tunney M. D.
. 19 (Address) 812 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dorchester Md	Oct 27 1921
20 UNDERTAKER: William Cook	ADDRESS: 502 E Nor

St Paul's Church Via Tolchester Steamboat

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information should be complete in every detail. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58073

D 58073

CERTIFICATE OF DEATH.

H 5

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Westwood Ave., 15 WARD)

2-FULL NAME John R. Meard.

(a) RESIDENCE NO. 1714 Westwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie C. Meard

6 DATE OF BIRTH (month, day, and year) Sept 4-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51.	1.	21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Business.

(b) General nature of industry, business, or establishment in which employed (or employer) H 5

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James O Meard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Nannie C. Meard

(Address) 1714 Westwood Ave

15 Filed Oct 26 1921 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct' 26 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to Oct' 26, 1921, that I last saw him alive on Oct' 26, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & Rectum (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. M. Lamprin, M. D.

Oct 26 1921 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druncoods Va

DATE OF BURIAL Oct 28 1921

20 UNDERTAKER Wm Cook & Son

ADDRESS 502 E Hatton

c/o Edwin M. Savage via B. C. & A. Piscataway Co

26 1921

mation should be carefully supplied. Write plainly. Do not use abbreviations. Every question must be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be correctly classified. See instructions on back of certificates. TION is very important.

D 58074 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58074

CERTIFICATE OF DEATH. 167

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. University Hospital ST.: 17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roger W. Walker
(Residence in Baltimore: No. 402 E Lanvale st St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: March (Month) 6 (Day), 1901 (Year).

7-AGE: 20 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.
10-NAME OF FATHER: Harry M. Walker
11-BIRTHPLACE OF FATHER (State or Country): Balto Md
12-MAIDEN NAME OF MOTHER: Mary Roberts
13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry M. Walker
(Address) 402 E. Lanvale st

15- Filed Robert P. Harrison, 191
Burial Permit Clerk, Registrar.

16. Every item of information should be carefully classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

12 6 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy, or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Shock caused by 1st degree burns over body
(Duration) a few hours
CONTRIBUTORY (Secondary) Severe burns over entire body clothing caught fire from electric grate
(Duration) yrs. mos. ds.
(Signed) W K Gassaway M. D.
(Coroner.)
Oct 26. 1921. (Address) 117 W Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem. DATE OF BURIAL, Oct 28 19 21
20-UNDERTAKER: Wm Cook ADDRESS: 502 E. North Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58075

HEALTH DEPARTMENT—CITY OF BALTIMORE

150

D 58075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones

(a) RESIDENCE. NO. 2105 Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. min.
				1 hrs. 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Hance Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mildred Medairy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Hance Jones (Address) 2105 Calvert St.

15 Filed OCT 27 1921 ROBERT I. KERR Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 26 . 1921 . to Oct 26 . 1921 . that I last saw h[illegible] alive on Oct 26 . 1921 . and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Congenital Malformations

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Stanley Gorsuch M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Oct 29 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Edwin N. Sawkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58076

D 58076

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Baldies ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin N Sawkins

(a) RESIDENCE. NO 1043 Baldies ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Ma	Wh.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fred A. Sawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Georgiana White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry A. Sawkins
(Address) 402 Wyman ave

15 Filed OCT 27 1921 19 ROBERT J. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1921, to Oct 26, 1921, that I last saw him alive on Oct 26, 1921, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac arthmia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) R Morley Hoag, M. D.

Oct 27 1921 (Address) 729 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 28 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. Do not use abbreviations. Do not write in the space below. Use back of certificates.
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1315 86 64

D 58077

REGISTERED NO. D 58077

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Jackson

(a) RESIDENCE NO. 132 N. Washington St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs 1 mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Irwin Lee Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dorothy Davidson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address)

15 FILED OCT 27 1921 ROBERT J. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25th, 1921, to Oct 26th, 1921, that I last saw h[illegible] alive on Oct 26th, 1921, and that death occurred, on the date stated above, at 12[15] P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hypertension. Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Abbe Eversman, M. D.

10-26-1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Druid Cemetery 10/28/21

20 UNDERTAKER — ADDRESS

Theodore White 113 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Stars 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58078

D 58078

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 5 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Hamilton

(a) RESIDENCE No. 256 Colvin St. St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ?
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C. D. C.

PARENTS

10 NAME OF FATHER John Hamilton

11 BIRTHPLACE OF FATHER (City or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Armstrong

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Maryland.

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 OCT 27 1921 BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17 . 1921 . to Oct 24th . 1921 . that I last saw h[illegible] alive on Oct 24th . 1921 . and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Myocardial Insufficiency
Luetic Aortitis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. B. Stevenson, M. D.

10-25, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 10/27/21

20 UNDERTAKER Geo. A. Pulk — ADDRESS 1735 Gaston Ave

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58079

CERTIFICATE OF DEATH.

51 D 58079

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Warren Ave ST.) 22 WARD)

2-FULL NAME Georgia Theresa Young

(a) RESIDENCE. No. 222 Warren Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 3 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Va.

PARENTS

10 NAME OF FATHER Geo M Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Staven City Va.

12 MAIDEN NAME OF MOTHER Lucy M Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winchester Va.

14 Informant Lucy May Young
(Address) 226 Webster Ave

15 Filed ....., 19.... Registrar

OCT 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar, 19 11, to Oct 25, 19 21,
that I last saw her alive on Oct 25, 19 21,
and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation 11 yrs
Parenchymatous Nephritis 6 mos.
Exophthalmic Goitre 2½ yrs.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Geo A Strauss Jr, M. D.

10/26, 1921 (Address) 1935 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchester Va	Oct. 29 1921
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See back of certificates.
TION is very important. See instructions on back.

Spec.—6-9-19—B. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58080

63-001 D 58080

CERTIFICATE OF DEATH.

D 58080

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 129 N. Amity ST. 18 WARD)

2-FULL NAME Fitzhugh Lee Robinson

(a) RESIDENCE. NO. 129 N. Amity ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Back. Baltimore

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Sam Robinson
(Address) 129 N Amity St

15 OCT 27 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Oct 27, 1921, that I last saw h[illegible] alive on Oct. 25, 1921, and that death occurred, on the date stated above, at 1 h m.

The CAUSE OF DEATH* was as follows:

Polio-Myelitis Ant.

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

(Address) 939 W Fayette St

Oct 27/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Oct 27 1921

20 UNDERTAKER J L Blowndson ADDRESS 107 mont

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

D 58081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 803 S. Green St. ST.: 22 28 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Odelle Cook.(C)

(Residence in Baltimore: No. 803 S. Green St. St.: yrs. 16 mos. 6 ds. 28)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, March 26th. 1905, 1
(Month) (Day) (Year)

7-AGE. 16 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Charles Cook.(C)

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Lottie McCoy.(C)

13-BIRTHPLACE OF MOTHER (State or Country). Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Johnson.(C) mother

(Address) 803 S. Green St.

15- Filed OCT 27 1921 ROBERT J. KRAUTER Registrar

N.B.—Every item of information should be carefully considered, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner.)

Oct 24, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Oct. 27, 1921
20-UNDERTAKER	ADDRESS
Jas. L. Scott & Bro.	466 W. Lanvale St.

Spec.—1-10-21—M&T—1500 Bks.

D 58082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

D 58082

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Somerset ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Corrine Hilson

(a) RESIDENCE NO. 417 Somerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Robert Hilson

6 DATE OF BIRTH (month, day, and year) Jan 2 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore md.

PARENTS

10 NAME OF FATHER Hickerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clara Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Addella Green (Address) 423 N Stiles St

15 Filed OCT 27 1921 ROBERT A LEUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-24 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Oct 24, 1921, that I last saw her alive on Oct 24, 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Parenchy matous nephritis.

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

10/26 (Signed) Bernard S. French, M. D.

, 19 (Address) 1707 Eamondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakin Cemetery	Oct-27 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

mation should be careful... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-089 D 58083

D 58083

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2420 Oak St (ST.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannie Heath

(a) RESIDENCE. (No.) 2420 Oak St (ST.) (WARD.)
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col. aa	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov. 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None $00

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer X

9 BIRTHPLACE (city or town) Born in Balt Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wilson Heath

11 BIRTHPLACE OF FATHER (city or town) Cambridge
(State or country) Maryland

12 MAIDEN NAME OF MOTHER E Worton

13 BIRTHPLACE OF MOTHER (city or town) King George
(State or country) Virginia

14 Informant Bell Heath
(Address) 2420 Oak St

15 Filed ..... 19 ..... Registrar

OCT 27 1921 Bureau of Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23 1921 to Oct 26 1921, that I last saw h.. alive on Oct 26th 1921, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(duration) 4 yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Chas L Hall, M. D.

19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 27 1921
20 UNDERTAKER Mrs B A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See back of certificates. TION is very important. See instructions on back of certificates.

Spec. 6-0-19—H. P. Co.—1000 Blks.

D 58084

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mc Manus

(a) RESIDENCE. No. St. Thomas Ont. Canada ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 29th 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	11	26	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Thomas Ont. Canada

PARENTS

10 NAME OF FATHER Thos. Mc Manus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) JOHNS HOPKINS HOSPITAL, Records

15 Filed . 19 Registrar

OCT 27 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24th, 1921, to Oct 26th, 1921, that I last saw him alive on Oct 26th, 1921, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not

Did an operation precede death? Yes Date of 10/26/21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Dr. Emile Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Ont. Canada	10/27 1921

20 UNDERTAKER Chas F. Evans & Son ADDRESS 1180 N. Roger St.

CAUSE OF DEATH in plain terms, so that no other than a medical term may be used. Information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58085

CERTIFICATE OF DEATH.

64 D 58085

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2058 Kennedy Ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Dawson

(a) RESIDENCE. No. 2058 Kennedy Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 10. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Geo. B. Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Annie Eliza Potter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant George Dawson (Address) 2058 Kennedy Ave.

15 Filed ..., 19... Registrar

OCT 27 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 19 21

17

I HEREBY CERTIFY, That I attended deceased from Oct 26, 1921, to Oct 26, 1921, that I last saw h.r. alive on Oct 26, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Ryan, M. D.

, 19 (Address) 1100 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: 10/29/1921

20 UNDERTAKER: Chas F. Ewart & Son ADDRESS: 118 W. Mt Royal Ave

CAUSE OF DEATH must be stated plainly. Do not use abbreviations or technical terms. Omissions will delay burial. Read carefully the instructions on back of certificate. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58086 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58086

CERTIFICATE OF DEATH.

91V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2271 Wash. Road ST.: 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Meinecke

(a) RESIDENCE. NO. 2271 Wash. Rd ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. H. Meinecke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Katherine Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant Katherine Meinecke

(Address) 2271 Wash. Rd.

Filed OCT 27 1921 19.. ...ER ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1921, to Oct 24, 1921, that I last saw h— alive on Oct 24, 1921, and that death occurred, on the date stated above, at 11 50 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Blair, M. D.

(Address) 1127 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct. 27 1921

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Form 6-9-19—H. P. Co.—1000 Blks.

D 58087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 109

D 58087

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Heldenbridle

(a) RESIDENCE. No. West Monster Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John B. Heldenbridle

6 DATE OF BIRTH (month, day, and year) July 2 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Aaron Leister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sophia Louis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John B. Heldenbridle

(Address) Westminster Md

15 Filed OCT 2 1921 J E Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23. 1921, to Oct. 27. 1921, that I last saw her alive on Oct. 27 1921, and that death occurred, on the date stated above, at 6.35A m.

The CAUSE OF DEATH* was as follows:

Central Hernia.

(duration) 32 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post Operative Enterolend

Obstruction (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? West. Minster. Md.

Did an operation precede death? Yes Date of Oct. 25. 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Metcalf, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Meadow Brand	Oct 29th 1921
20 UNDERTAKER	ADDRESS
H Bamhard & Son	Westminster Md

mation should be carefully supplied. Age should be given in YEARS, MONTHS and DAYS. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58038

D 58088

CERTIFICATE OF DEATH.

REGISTERED NO. 9 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3012 Ellerslie Ave ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Priscilla Drane

(a) RESIDENCE. NO. 3012 Ellerslie Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Drane

6 DATE OF BIRTH (month, day, and year) May 19th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Boyd Linn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Scotchburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs J. Kenny 3012 Ellerslie Ave.

15 Filed OCT 26 1921 J. H. Wehr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 18th 1921, to Oct 25th 1921

that I last saw her alive on Oct 25th 1921

and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 7 mos. ds.

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Geo. Thompson M. D.

10 E 25th St (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Oct 28 1921

20 UNDERTAKER C. A. Windsfeld ADDRESS 501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58089

CERTIFICATE OF DEATH.

108 D 58089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Wallace

(a) RESIDENCE. No. 832 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Nicholas Wallace

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Patrolman #61

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer State of Md. Balto., Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Anne Lapeaux

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.,

14 Informant Mrs. Nicholas Wallace.

(Address) 832 Hollins st.

15 Filed OCT 27 1921 19 ROBERT I. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1921. to Oct. 25. 1921; that I last saw him alive on Oct. 25, 1921. and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic appendicitis

Diverticulitis (Meckels).

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia (general peritonitis)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Oct. 23, 1921.

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation - laboratory

(Signed) J. W. Guyton, M. D.

, 19 (Address) University Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	10-28 1921
20 UNDERTAKER	ADDRESS 17
Robert Brooks & Son	S. Calhoun

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back

D 58090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58090

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1314 Argyle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. E. Tilghman

(Residence in Baltimore: No. 1314 Argyle Ave. St.: 40 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widower

6-DATE OF BIRTH, April 10, 1881
(Month) (Day) (Year)

7-AGE, 81 yrs. 6 mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Chas Tilghman

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Scott ?

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob E. Tilghman

(Address) 1314 Argyle Ave

15- ROBERT S. BRAUER

FILED OCT 27 1921 DEPUTY REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophy heart disease

(Duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) and Senility

(Duration) yrs. mos. da.

(Signed) J. T. Hennessy M. D.
(Coroner)

Oct. 26, 1921 (Address) 202 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Oct. 28, 1921

20-UNDERTAKER Clarence E. Wilson — ADDRESS 1364 W. Cary

N. B.—Every item of information must be given if possible. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of date of death is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks. 1210 Jefferson St White ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58091 X 39 D 58091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Stephens

(a) RESIDENCE No. US. Public Health Hosp. #56 ST., -- WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs George E Stephens

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosembrock Registrar
(Address) US PHS Hosp. #56 Balto, Md.

15 Filed OCT 27 1921 ROBERT J KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25. 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 21, 19 21 to Oct 26, 19 21.
that I last saw him alive on Oct 25, 19 21.
and that death occurred, on the date stated above, at 9'20 P.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of gums, Rt. upper Jaw.

July 21/21 (duration) -- yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary) Metastasis

-- (duration) -- yrs. -- mos. -- ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Truman R. Payne M. D.
Senior Surgeon (R)

10/25. 1921 (Address) US PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Oct 28 1921
20 UNDERTAKER	ADDRESS
S Lawson & Bro	E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone insufficient. Deaths from violence must state MEANS and NATURE of INJURY, and whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Indefinite or unsatisfactory answers cannot be accepted. Write plainly and use ink. Fill every blank for which you have answers. Do not omit any item because it may be known to the Registrar. Information required by law. Penalty for refusing or neglecting to furnish it, or for making false statements, $5.00 to $50.00. (See Sec. 1309, Ordinances of 1915.) Read carefully the instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58092

CERTIFICATE OF DEATH.

REGISTERED NO. 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Mercy Hospital ST.: (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edith Shank

(a) RESIDENCE. (NO.) 3 W Lanvale St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Charles Shank

6 DATE OF BIRTH (month, day, and year): Nov. 12 1887

7 AGE: Years 33 Months 11 Days 14 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Pohle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ella Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs Ella Pohle. Middleburg. Carroll County.

15 Filed OCT 27 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1921, to Oct 25, 1921, that I last saw h.r alive on Oct 25, 1921, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Surgical operation for Retroplacements of uterus & Cystocele.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Oct 24 1921

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas J Cobb M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middleburg. Carroll County. DATE OF BURIAL: Oct. 27 21

20 UNDERTAKER: George J. Ruth. ADDRESS: 1735 Hanford Ave.

CAUSE OF DEATH in plain terms, as far as possible. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 58093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58093

CERTIFICATE OF DEATH.

170

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 E. Chase ST., 10 WARD)

2-FULL NAME Sue Ann McBee

(a) RESIDENCE NO. 609 E. Chase ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	W	Married

5a If married, widowed or divorced) HUSBAND of / WIFE of Charles T McBee

6 DATE OF BIRTH (month, day, and year) July 12-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va.

PARENTS

10 NAME OF FATHER Jacob Rhodes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinsburg W. Va.

12 MAIDEN NAME OF MOTHER Sue Ann Rhodes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Mary I. Magessed. (Address) 609 E. Chase st

15 OCT 27 1924 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1924, to Oct 26, 1924, that I last saw her alive on Oct 26, 1924, and that death occurred, on the date stated above, at 12.55 P.m.

The CAUSE OF DEATH* was as follows:

Ch. Parenchymatous nephritis

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Laryngeal paralysis.

(duration) yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary & Physical

(Signed) A. L. Bornstein, M. D.

10/27/1924 (Address) 733 Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 29 1924

20 UNDERTAKER William Cook — ADDRESS 502 E North

mation should be carefully ... so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58094

CERTIFICATE OF DEATH.

127 D 58094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Black

(a) RESIDENCE. NO. None ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	~~Black~~ White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pottsville, Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1921, to October 23, 1921, that I last saw him alive on October 23, 1921, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Hydronephrosis

(about 2 yrs.) (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Broadrup, M. D.

10/24/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

OCT 2 1921

CAUSE OF DEATH in plain terms, so that it may be understood by the public generally. Name of disease alone is not sufficient. Indefinite terms, such as "Debility," "Old Age," "Exhaustion," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Convulsions," "Paralysis," "Dropsy," "Cramps," "Stroke," "Fright," "Shock," "Sudden Death," "Found Dead," "Killed," "Accident," "Suicide," "Homicide," are not sufficient. Medical certificate of death must be filled out by physician. Penalty for failure to report death, or for making false report, or for violation of any of the provisions of the law governing the registration of deaths and issuance of certificates. TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Blks.

Duplicate

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58095

CERTIFICATE OF DEATH.

15 D 58095

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 425 N. Durham ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bell

(a) RESIDENCE. No. 425 N. Durham ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 24-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thos Bell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mabel Chase

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mabel Chase
(Address)

15 Filed Oct 27 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 24, 1921, to Oct 25, 19...,

that I last saw h... alive on Oct 24, 1921,

and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth 8 days
Month pregnancy
(duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Neonatal
(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm C Burns, M. D.

Oct 26 19 21 (Address) 1818 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	Oct 2 1921

CAUSE OF DEATH must be plainly written. See instructions on back of certificates.
TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 58096

D 58096 CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Marek

(a) RESIDENCE. NO. 8781 E. Fairmount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Joseph Hospital

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Robert P. Harrison,
Address

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1921, to Oct 27, 1921, that I last saw h him alive on Oct 27, 1921, and that death occurred, on the date stated above, at 10:10 m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. N. Freeman, M. D.

, 19 (Address) 2631 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL OCT 2 1921

20 UNDERTAKER Commissioner Health.

ADDRESS

OCT 2 1921 Burial Permit Issued

CAUSE OF DEATH to be plainly written, and state if from accident, suicide or homicide. See that every question is answered. Information is very important. See instructions on back of certificates.

D 58097

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 58097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Balto Barcoing House Baltimore Liberty st Balt ST 23 WARD)
REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Bond Peters

(Residence in Baltimore: No. 1039 N. Charles st — St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb (Month) 3 (Day), 1870 (Year)

7-AGE, 51 yrs. 8 mos. 22 dys.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retail Shoe Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Byrd

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Elizabeth Cookes

13-BIRTHPLACE OF MOTHER (State or Country), York Penn'd

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno V. Peters

(Address) 1039 N. Charles St

15- Robert P. Harrison,
(Date) Burial Permit Clerk. (Registrar.)

N.B.—Every item of information called for by this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... (~~Jurors,~~ ~~Jury or~~ inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
a few hrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) W. R. Gorsuch M. D.
(Coroner)

10.27, 1921. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, 10/28, 1921

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

N.B. 27 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58098

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 St. Paul ST.: 12 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Y. Heaphy

(a) RESIDENCE. No. 1718 St. Paul ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Solicitor 071

(b) General nature of industry, business, or establishment in which employed (or employer): R. G. Dunn & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: William V. Heaphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Virginia Kershner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: William V. Heaphy

(Address) 1718 St. Paul Street

15 Filed 10 27, 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/1921

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1921, to Oct 26, 1921, that I last saw him alive on Oct 26, 1921, and that death occurred, on the date stated above, at 11. a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

OVER

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

2 hours (duration) — yrs. — mos. — ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W. T. O'Meara, M. D.

10/27 1921 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/28, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of any other abnormal condition. Endocarditis cause of embolism.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58099 ✓

D 58099

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Mercy Hospital ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Higgins

(a) RESIDENCE. NO. 1834 E. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mercy Hospt

(Address)

OCT 27 1921 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Oct 26, 1921, that I last saw her alive on Oct 26, 1921, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) (3) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) 12 hrs yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) John L. Brown, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Oct 30 1921

20 UNDERTAKER Harlan Baker ADDRESS Somerset W Fayette

CAUSE OF DEATH in plain terms, so that a layman can understand. See instructions on back of certificates. TION is very important.

D 58100 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58100

56

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mersity Hospital ST. 18 WARD)
REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mot Eekstein

(Residence in Baltimore: No. 16 N Fremont st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Oct 2nd, 1875 (Month) (Day) (Year)

7-AGE: 46 yrs. mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hedwig Kunze

(Address) 16 N Fremont Ave

15-

Filed ....., 191.... Registrar.

Robert P. Harrison, Deputy Permit Clerk

OCT 27 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

From History. Acute Alcoholism

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Jozsel M. D. (Coroner)

10.27. 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Oct 28th 1921

20-UNDERTAKER, Wm Jos John W Feusel Son

ADDRESS 20 N. Fayette St.

N.B. Every item must be filled in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.
CAUSE OF DEATH

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58101

D 58101

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 627 N. Calvert ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Washington Welsh

(Residence in Baltimore: No. 627 N. Calvert St.: 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Mar.

6-DATE OF BIRTH, October 23, 1860
(Month) (Day) (Year)

7-AGE, 61 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Franklin Co. Pa.

PARENTS.

10-NAME OF FATHER, John Welsh

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Rebecca Meisner

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence E. Willard

(Address) 2019 Penna. ave

15-

Filed OCT 27 1921 F. Wilm Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17 1921, to Oct. 26, 1921, that I saw h[illegible] alive on Oct. 26, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Aortic Stenosis
(Chronic Valvular Disease of the Heart) (Duration) 7 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John B. Hutchcombe M. D.

Oct. 1, 1921 (Address) 1316 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. 6 mos. ds. In the State yrs. 6 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Fairview, Franklin Co. Pa.

19-PLACE OF BURIAL OR REMOVAL, Edgemont Penna. DATE OF BURIAL, Oct. 28th, 1921.

20-UNDERTAKER Leo G. Cook ADDRESS Northern Parkway ave

CAUSE OF DEATH must be plainly written. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58102

CERTIFICATE OF DEATH.

89 D 58102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Patterson Pk ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Krawczyk.

(a) RESIDENCE. No. 607 S. Patterson ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write this word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Aug 4-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Krawczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Hammuth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Peter Krawczyk
(Address) 607 S Patterson Pk.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 1921

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1921, to October 27, 1921, that I last saw h.... alive on October 27, 1921, and that death occurred, on the date stated above, at 6 5/8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 0 mos. 16 ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Fassnacht M. D.

, 19 (Address) 243 Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Oct. 28 1921

20 UNDERTAKER, ADDRESS

W. F. Hallsworth 764 Eastern

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

T 27 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58103

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 Thames ST.: E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Walters

(a) RESIDENCE. NO. 1832 Thames ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Walters

6 DATE OF BIRTH (month, day, and year) Sept 4. 1847

7 AGE Years	Months	Days	If LESS than 1 day, Hrs. or min.
74	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baden, Germany

PARENTS

10 NAME OF FATHER — Neale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Henry Walters
(Address) 1832 Thames St

15 Filed OCT 27 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6 1918 to Oct 27 1921.

that I last saw her alive on Oct 26 1921.

and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Leo. Heller M. D.

10 27 21 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st German Evg	Oct 30 1921

20 UNDERTAKER Peter Nicolaus — ADDRESS 2046 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be a permanent record. See instructions on back of certificates.

D 58104

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 001 D 58104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kutz

(Residence in Baltimore: No. 25 20 Fleet St.: 6 yrs., 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Boy

6-DATE OF BIRTH: Sep. 22, 1915 (Month) (Day) (Year)

7-AGE: 6 yrs. 1 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Henry Kutz

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Agnes Warczynski

13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Kutz

(Address) 25 20 Fleet St.

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

Oct 27 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct. 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Pleurisy

Acute

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Conley M. D.
(Coroner)

10-28 1921 (Address) Cor. of Coroners

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Rosary — DATE OF BURIAL: Oct. 28, 1921

20-UNDERTAKER: John A Weber — ADDRESS: 803 Bank St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1509 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58105

D 58105

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edmondson Ave Ten Hills ST., 78 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Henry Blanck

(a) RESIDENCE NO. Edmondson Ave Ten Hills ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 69 yrs. 0 mos. 27 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Bertha Lippe Blanck

6 DATE OF BIRTH (month, day, and year) Sept. 29 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 045

(b) General nature of industry, business, or establishment in which employed (or employer) Soap manufacturer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Blanck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Roemer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Bertha Lippe Blanck Son Wallis
(Address)

15 DEC OCT 28 1921 [illegible] Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1921, to Oct. 26, 1921, that I last saw him alive on Oct. 26, 1921, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Primary
Cause unknown
(duration) many yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) ✓
(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) C. Hamilton Jones M. D.

, 19 (Address) 2524 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 28 1921

20 UNDERTAKER John O. Mitchell — ADDRESS 120 W. Fayette

CAUSE OF DEATH in plain terms, so that if may be properly coded. See instructions on back of certificates. IMPORTANT. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58106

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 N. Eden ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Hall

(a) RESIDENCE. NO. 1530 N. Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND) (or) WIFE of J. Franklin Hall

6 DATE OF BIRTH (month, day, and year) Feb. 12-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Daugherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. Naylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Carrie Hall
(Address) 1530 N. Eden St.

15 Filed OCT 28 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1921, to Oct 25, 1921, that I last saw h alive on Oct 25 1921, and that death occurred, on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH* was as follows:

Endocard. (Mitral)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) arthritis
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) H. Simms, M. D.

Oct 27 1921 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Oct. 29 1921

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH in plain terms. So that a medical man may understand it. See instructions on back of certificates. TION is very important.

Burial Permit Blank

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58107 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58107

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N. Kenwood ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rusteberg

(a) RESIDENCE. No. 706 N. Kenwood ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Rusteberg

6 DATE OF BIRTH (month, day, and year) Nov 19 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ludwig Rusteberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Caroline Rusteberg (Address) 706 N. Kenwood ave.

15 Filed OCT 28 1921 ROBT. J. KRAUTER Registrar

Burial permit Oct 28

CAUSE OF DEATH in plain terms, so that it may be understood by the layman. Each item of certificate is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 1921, to Oct 26 1921, that I last saw h[illegible] alive on Oct 26 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Gerling, M. D.

Oct 27 1921 (Address) 1400 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	Oct. 29 1921

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D 58108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 79 ✓ D 58108

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fredevica Brennels

(Residence in Baltimore: No. Acequith 24 Rockland Ave St.; ..... yrs., 2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... September ..... 17 ....., 1844
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
77 yrs. 1 mos. 9 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baden Germany

PARENTS.

10-NAME OF FATHER, Karl Brennels

11-BIRTHPLACE OF FATHER (State or Country), Baden Germany

12-MAIDEN NAME OF MOTHER Maria Schanz

13-BIRTHPLACE OF MOTHER (State or Country), Baden Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionede

(Address) Motherhouse of Notre Dame

15- Filed OCT 28 1921 ROBERT J. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October ..... 26 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 16 1921, to October 26 1921, that I saw h.r alive on October 26 1921, and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

..... Chronic Myocarditis .....
..... Adiatation of Heart .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)
..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) ..... F. J. Kelly ..... M. D.
Oct 27, 1921. (Address) 110 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md	Oct 29, 1921
20-UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St.

Important. See instructions on back of certificate.

D 58109

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

MD 58109

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 508 Woodlawn Rd. Roland Park ST. 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Elizabeth Medcalf

(Residence in Baltimore: No. Roland Park. Md. St. 12 yrs. ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (Write the word) Widowed

6 DATE OF BIRTH Nov. ? , 1855 (Month) (Day) (Year)

7 AGE 68 yrs. ? mos. ? ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Boarding House
(b) General nature of industry, business, or establishment in which employed (or employer) Self

086

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. A. McLanahan

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Sarah Murray

13 BIRTHPLACE OF MOTHER (State or country) Louisiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Sarah Medcalf (daughter)

(Address) 508 Woodlawn Road

15 ~~ROBERT A KRAUTER~~

OCT 28 1921 Burial REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 27th , 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11th , 1921 , to. Oct 27th 1921 .
that I saw her alive on Oct 26th , 1921 .
and that death occurred, on the date stated above, at 6 05 A.m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) [redacted] yrs. mos. 14 ds

Contributory (SECONDARY) Chr. Emphysema

(Duration) 8 yrs. mos. ds.

(Signed) Ebenezer R. Clarke M. D.

Oct 27th 1921 (Address) Roland Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted. —

If not at place of death? Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Green Mount Cemetery | DATE OF BURIAL Oct 29 1921

20 UNDERTAKER'S NAME STEWART & MOWER COMPANY (WILLIAM F. [redacted], Successor) | ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. Address should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58110

CERTIFICATE OF DEATH.

146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 625 W. Franklin ST.: 15 WARD)

2-FULL NAME Ludwig G. Hartig

(a) RESIDENCE. (Usual place of abode) No. 3110 Presbury ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Sophia J. Hartig

6 DATE OF BIRTH (month, day, and year) June 29th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Hartig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Sophia J. Hartig 3110 Presbury St

15 Filed OCT 28 1921 19 [illegible] Registrar

Burial Permit Office

CAUSE OF DEATH in plain terms, so that it may be understood. See back of certificates. TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 - , 1921, to Oct. 26 , 1921, that I last saw him alive on Oct. 25 , 1921, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Mastoiditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Septic meningitis -

(duration) yrs. mos. 6 ds.

18 Where was disease contracted - If not at place of death? at home -

Did an operation precede death? Yes Date of Oct. 15/21

Was there an autopsy? No -

What test confirmed diagnosis? Laboratory + Spinal puncture

(Signed) Jesse W. Downey, M. D.

19 (Address) 529 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 29th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~157268~~ ~~D 58111~~ 78 D 58111

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Otto Ehlers. Balto. Md.

(a) RESIDENCE. No. 1224 N. Broadway. St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 Y. 8 M. 7 Ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mrs. Florettie Ehlers (wife)

6 DATE OF BIRTH (month, day, and year) Feb. 20, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51.	8.	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draftsman

(b) General nature of industry, business, or establishment in which employed (or employer) Otis

(c) Neme of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Arend Ehlers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Segler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Date OCT 28 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1921. to Oct 27, 1921. that I last saw him alive on Oct 27, 1921. and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

PLEURISY WITH EFFUSION

OVER

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L Dorsey, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 31st 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

CAUSE OF DEATH in plain terms. Abbreviations not allowed. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably tuberculous

D 58112

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 58112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robt Garrett Hosp for Children

REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N Carey ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Kent

(a) RESIDENCE. No. 413 S. Norris ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Harry Kent

11 BIRTHPLACE OF FATHER (city or town) Bath
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Shirey

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Shirey
(Address) 413 S Norris St

15 OCT 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1921, to Oct 28, 1921, that I last saw h in alive on Oct 27 1921, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Chas. Cliff, M. D.

10/28. 1921 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Oct 29 1921
20 UNDERTAKER John L Fuller 1200 W Lombard	ADDRESS

CAUSE OF DEATH in plain terms. Indefinite and unscientific terms cannot be used. Certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58113

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kruck (Skruck) (Stanislaw Skruch)

(a) RESIDENCE. No. 510 S. Wolfe st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Kruck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Josephine ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Interment Hospital Records

(Address) M.T.H.

15 Filed OCT 28 1921 19 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to Oct. 26, 1921, that I last saw him alive on Oct. 26, 1921, and that death occurred, on the date stated above, at 11.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Exp. Ln sputum, X-ray

(Signed) Francis L. Badgleacer M. D.

10-27-21 19 (Address) Municipal Tr Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	October 29. 1921.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 905 S Ann St

CAUSE OF DEATH to be plainly written, without abbreviations. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

091 X 104 D 58114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ruth D. Talley

(a) RESIDENCE. NO. Myrtle Ave, Rosedale, Md WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
10	19		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Doc Talley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Wilhelmina Ketzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed OCT 28 1921 19 BOBER : ABBOTT Registrar

Burial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

t6 DATE OF DEATH (month, day, and year) 10-27 1921

t7

I HEREBY CERTIFY, That I attended deceased from 10-27, 1921, to 10-27, 1921, that I last saw h[illegible] alive on 10-27, 1921, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

10/27, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Oct. 29 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58115

CERTIFICATE OF DEATH.

120 ✓ D 58115

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 N. Stocketon ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Randall

(a) RESIDENCE NO. 1132 N. Stocketon ST., ... WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Staunton Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lizzie Randall
(Address) 1132 Stocketon St

15 Filed OCT 28 1921 19 .....

[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15 - 1921, to October 25 1921, that I last saw her alive on October 25, 1921, and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy
Chronic Bright Disease (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease (duration) ..... yrs. 6 mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. W. Leonard M. D.

10-25-21 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 28 1921
20 UNDERTAKER	ADDRESS
Edward Pumphrey	1462 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58116

CERTIFICATE OF DEATH.

D 58116

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3519 Gough ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Harris

(a) RESIDENCE NO. 3519 Gough ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma J. Harris

6 DATE OF BIRTH (month, day, and year) Aug 20 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James G. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Contryon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Ella V. Brown

(Address) 3519 Gough St

15 Filed OCT 28 1921 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26th 1921

17 I HEREBY CERTIFY, That I attended ~~deceased~~ from Jan 18th, 1920, to Oct 26th, 1921, that I last saw him alive on Oct 10th, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx

(duration) 1 yrs. 10 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Muscat bacilli

(Signed) W. S. Thayer M. D.

(Address) 737 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 10-29 1921

20 UNDERTAKER John A Moran — ADDRESS 800 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Statistical information should be entered on back of certificates. See Instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58117

CERTIFICATE OF DEATH.

5 - 79 ✓

D 58117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Aisquith St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Lee

(a) RESIDENCE. No. 207 Aisquith St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1854

7 AGE 67 Years 1 Months 7 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vas

14 Informant Mary Handy
(Address) 207 Aisquith St

15 OCT 28 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1921, to Oct 27, 1921, that I last saw her alive on Oct 26, 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Dilitation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

10-27-1921 (Address) 1672 Mount

10-27-21

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 29 1921
20 UNDERTAKER	ADDRESS
Theo White	113 S Wolfe St

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58118

CERTIFICATE OF DEATH.

120 D 58118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 W. Lombard ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Catherine Kernan

(a) RESIDENCE. NO. 1228 W. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or symptoms. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Kernan

6 DATE OF BIRTH (month, day, and year) March 15, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Patrick Caton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Roche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Kernan

(Address) 3600 Calloway ave

15 Filed OCT 28 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Oct. 26, 1921, that I last saw her alive on Oct. 26, 1921, and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis, B.P. etc

(Signed) W. H. Triplett, M. D.

. 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 29. 1921
20 UNDERTAKER H. C. Brauning Son	ADDRESS 517 N Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58119

CERTIFICATE OF DEATH.

D 58119

REGISTERED NO. 152

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. Mercy Hospital ST.: 4 WARD)

2-FULL NAME Baby Ebert (male)

(a) RESIDENCE. No. Galveston Court ST., Washington D C WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 36 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct 26 1921

7 AGE: Years — Months — Days — If LESS than 1 day, 9 hrs. or 36 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Mercy Hospital Balto Md

PARENTS

10 NAME OF FATHER: Jerrold Ebert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Clara Brooks Crumbo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: J. S. Ebert

(Address): Washington DC

15 Filed: OCT 28 1921 ROBERT I. KRAUTH Registrar

Burial Permit Given

CAUSE OF DEATH in plain terms, so that a lay person can understand it. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1921, to Oct 26, 1921, that I last saw him alive on Oct 26, 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Breech Presentation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Injury

(duration) 9 hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) John J Brown, M. D.

19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Oct 28th 1921

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Balto St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58120

CERTIFICATE OF DEATH.

40D 58120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N. Fulton Ave. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Enoch H. Lisle

(a) RESIDENCE. NO. 211 N. Fulton Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie E. Lisle

6 DATE OF BIRTH (month, day, and year) Jan. 27" 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Marsailles
(State or country) France

PARENTS

10 NAME OF FATHER William Lisle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) France

12 MAIDEN NAME OF MOTHER Sutton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Mollie E. Lisle
(Address) 211 N. Fulton Ave.

15 OCT 28 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26" 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7th, 1921. to Oct. 26th, 1921.
that I last saw him alive on Oct. 26th, 1921.
and that death occurred, on the date stated above, at 2.15 P.m.
The CAUSE OF DEATH* was as follows:

Exhaustion (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of the Oesophagus (duration) yrs 2 mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Boulton M. D.

10/27 1924 (Address) 654 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Oct 29 1921

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 N. Balto St

CAUSE OF DEATH to plainly state, so that a ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58121

CERTIFICATE OF DEATH.

120 D 58121

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Jefferson ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard W. Proctor

(a) RESIDENCE. No. 2109 Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Martha Houston Proctor

6 DATE OF BIRTH (month, day, and year) Feb 21 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Maryland

PARENTS

10 NAME OF FATHER: Robert Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rxx Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Maryland

14 Informant: Martha Proctor
(Address): 2109 Jefferson St.

15 Filed OCT 28 1921 J. Wilson Registrar

CAUSE OF DEATH in plain terms, so that no other cause may be substituted. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1921 to Oct 28. 1921, that I last saw h[illegible] alive on Oct 27 1921, and that death occurred, on the date stated above, at 1:00 A m.

The CAUSE OF DEATH* was as follows:

Chr Par Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Wass & Phy Ex-

(Signed) G. C. Blades, M. D.

. 19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Oct. 31-21 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58122 151539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 58122

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michela Climenti

(a) RESIDENCE NO. 272 Exeter St. City ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonio Climenti

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If less than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed OCT 28 1921 19 ROBERT J. KELOTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921 to Oct. 27, 1921.

that I last saw her alive on Oct. 24, 1921 19

and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 272 N. Exeter St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? x Ray —

(Signed) Patterson, M. D.

10-27, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Vincent Cem.

DATE OF BURIAL 10/29/21 19

20 UNDERTAKER Geo. J. Puth. ADDRESS 1735 Hanford Ave.

CAUSE OF DEATH in plain terms. So that a ... TION is very important. See instructions on ... on back of certificates.

D 58123 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D 58123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 909 Peach Alley. ST. 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alverta Green.(C)

(Residence in Baltimore: No. 909 Peach Alley.)

40 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, Do not know., (Month) (Day) 1 (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Chestertown, Md.

PARENTS.

10-NAME OF FATHER, John Turner.(C)

11-BIRTHPLACE OF FATHER (State or Country). Chestertown, Md.

12-MAIDEN NAME OF MOTHER Margaret Reynolds.(C)

13-BIRTHPLACE OF MOTHER (State or Country). Chestertown, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Demoy.(C) son.

(Address) 931 Plum Alley.

15- Filed ..., 191... Robert P. Harrison, Registrar.

OCT 28 1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Mac Reinhardt M. D. (Coroner.)

Oct. 28th. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn Cemetary	October 29 1921
20-UNDERTAKER M. Doyle	ADDRESS 15 E Lee St

R.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

(Slingluff)

D 58124 HEALTH DEPARTMENT--CITY OF BALTIMORE D 58124

CERTIFICATE OF DEATH

43

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1624 Bolton St. St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ann Montgomery Slingluff

(Residence in Baltimore: No. 1624 Bolton St. St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE Colored. | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July (Month) 9 (Day), 1858 (Year)

7 AGE 63 yrs. 3 mos. 19 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework. 037
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Missouri.

PARENTS

10 NAME OF FATHER Montgomery Johns

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Salome Siffendeffer

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Salome L. Slingluff

(Address) 16 W Bolton Street

15 Filed OCT 28 1921, 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

NB.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 (Month) 28 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1921, to Oct 28 1921, that I saw h[er] alive on Oct 26, 1921, and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Metastatic growth of lungs

(Duration) yrs. 7 mos. ds

Contributory (SECONDARY) Carcinoma - Breast.

(Duration) yrs. mos. ds.

(Signed) Harry S. McCarty M. D.

Oct 28, 1921 (Address) 817 W Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Druid Ridge Cemetery | DATE OF BURIAL 10/29, 1921

20 UNDERTAKER Henry W. Mears & Son | ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58125

HEALTH DEPARTMENT—CITY OF BALTIMORE

8.09 D 58125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Nursery & Childs Hosp ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger Miller

(a) RESIDENCE. NO. Schroeder & Franklin Sts. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 23 '21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER — ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) — ?

12 MAIDEN NAME OF MOTHER Bertha Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 OCT 28 1921 Robert P. Harrison, . 19
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20th, 1921, to Oct 24, 1921, that I last saw him alive on Oct 24, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mal J. Finnegan M. D.

Oct 24th 1921 (Address) 1062 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	OCT 27 1921
20 UNDERTAKER	ADDRESS
Commissioner Health.	

CAUSE OF DEATH to be filled in plain terms, so that it may be clearly understood. DATE of occurrence must be given. NAME of disease alone is not sufficient. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58126

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard + Jones. (St.) No (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Napolillo

(a) RESIDENCE. No. 3713 E. Pratt St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not Known.

6 DATE OF BIRTH (month, day, and year) 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 16 yr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Stephen Napolillo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Teresa Runnis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Philip Cuomo

(Address) 3927 E. Lombard St

15 Filed Robert P. Harrison, Registrar

28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/ 1921.

17 I HEREBY CERTIFY, That I attended deceased from 10/26/21, 19.., to 10/27/, 1921., that I last saw him alive on 10/27/, 1921., and that death occurred, on the date stated above, at 7 30/ A.m.

The CAUSE OF DEATH* was as follows:

~~Acute Appendicitis~~

General Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 3713 E Pratt St.

Did an operation precede death? yes Date of 10/26/21

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) W B Jones. M. D.

10/27 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cem	Oct 26 1921
20 UNDERTAKER	ADDRESS
Wendell Hippel + Son	5/ Lombard

CAUSE OF DEATH must be plainly written. TION is very important. See instructions on back of certificates.

(Alexander)

D 58127 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 64 D 58127

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 614 Raborg ST.: 4 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aalexander Bacon

(Residence in Baltimore: No. 614 Raborg St 40 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Colord	Widower

6-DATE OF BIRTH, Dont Know (Month) 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
71 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hack Driver
(b) General nature of industry, business, or establishment in which employed (or employer): 623

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Isaac Bacon

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha Wolf

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carolina Bacon

(Address) 1423 Myrtle ave

15- Robert F. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

28 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy, or)~~ inquiry.) thereon and from the evidence obtained by said ~~(inquest, autopsy or)~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch, M. D. (Coroner)

10-28-, 1921 (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Oct 29, 1921
20-UNDERTAKER	ADDRESS
Julius B. Pyle	102 E. Mulberry st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58128

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2455 W North Av. ST.: 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Bachman

(a) RESIDENCE. No. 2455 W North Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo Bachman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Kath Geise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Wm Kuhn
(Address) 10 S Calhoun St

15 Filed 2 3 1921, 19 Robert F. Harrison, Registrar [Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20th, 1921, to Oct 26, 1921, that I last saw h[illegible] alive on Oct 26, 1921, and that death occurred, on the date stated above, at 11 51 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Dan Cary, M. D.

10/28, 1921 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 29 '21
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W Lombard

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58129

151

D 58129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. # 1610 McCulloh ST., 14 WARD)

2-FULL NAME Mary Billgayer

(a) RESIDENCE NO. 1610 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	—	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Billgayer

11 BIRTHPLACE OF FATHER (city or town) Malta.
(State or country)

12 MAIDEN NAME OF MOTHER Dora Wilson

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant, Mrs Grandville Williams
(Address) 1610 McCulloch

15 Filed Robert F. Harrison, Registrar

28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-21

17 I HEREBY CERTIFY, That I attended deceased from 10-27- 21, to 10-27-21 19 .

that I last saw h Ewe alive on " 19 .

and that death occurred, on the date stated above, at 1060 m.

The CAUSE OF DEATH* was as follows:

Difficult Labor
Miscarriage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hereditary Rickets

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jno Caulfield, M. D.

10-28 1921 (Address) 1524 Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	10-29, 1921
20 UNDERTAKER J Leon Hall	ADDRESS 744 Dolphin

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

(Dora)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

151 D 58130

D 58130

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 McCulloh ST., 14 WARD)

2-FULL NAME Dora Williams

(a) RESIDENCE NO. 1610 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1/2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	single

5a If married, widowed, or divorced —
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-27-21

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	—	—	—	7

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Richard Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dora Kilroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Richard Williams
(Address) 1610 McCulloch St

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

OCT 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-1921

17 I HEREBY CERTIFY, That I attended deceased from 10-27-21, 19..., to 10-27-21, 19...,

that I last saw h alive on ..., 19...,

and that death occurred, on the date stated above, at 5 P. M., m.

The CAUSE OF DEATH* was as follows:

Difficult Labor
Miscarriage

(duration) ..... yrs. ..... mos 1/2 ds.

CONTRIBUTORY (Secondary) Rickets (Hereditary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of "

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J McCaddon, M. D.

, 19 (Address) 1524 O'Hill ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cmtry	Oct 29 1921
20 UNDERTAKER J Leon Hall	ADDRESS 741 D Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58131

HEALTH DEPARTMENT—CITY OF BALTIMORE

105

D 58131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Rutland ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M Griffin Jr

(a) RESIDENCE. No. 1007 Rutland ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs 11 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian M Griffin

6 DATE OF BIRTH (month, day, and year) Nov 21 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant (Address) Mrs Lillian M Griffin 1007 Rutland

15 Filed OCT 28 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1921 to Oct 26th 1921.

that I last saw him alive on Oct 25th 1921.

and that death occurred, on the date stated above, at 9:25 A m.

The CAUSE OF DEATH* was as follows:

Ulcerative Colitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F. B. Dellwatka M. D.

(Address) 877 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 29 1921
20 UNDERTAKER	ADDRESS
John Henning & Co	207 Orleans

CAUSE OF DEATH must be plainly written, and TION is very important. See instructions on b

s on back of certificates.

D 58132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58132

CERTIFICATE OF DEATH.

X 184

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Calli.

(Residence in Baltimore: No. Turners Station. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word)
Female	White	Married

6-DATE OF BIRTH, May (Month) 9 (Day), 1886 (Year)

7-AGE, 35 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE, (State or Country), Ohio.

PARENTS.

10-NAME OF FATHER, William Glover

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ohio.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Calli

(Address) Turners Station

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

28 1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstruction Self induced Injection of Bichloride.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Whit. Knoles, M. D. (Coroner)

10-28 1921 (Address) M. E. Odell,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Turners Station, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Oct 29, 1921.
20-UNDERTAKER	ADDRESS
John Lerch & Co	208 Paca.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58133

CERTIFICATE OF DEATH.

78 D 58133

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 N. Chapel ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bem

(a) RESIDENCE. No. 524 N. Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 15 1891

7 AGE: Years 30 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Bem

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Anna Rubacka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): John Bem 524 N Chapel St

15 Oct 28 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 19 21, to Oct 27, 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Under Treatment

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rowe M. D.

Oct 28, 19 21 (Address) 801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dale Hill	Oct 31 1921
20 UNDERTAKER	ADDRESS
Emil Zorb & Son	1906 Park Ave

TION is very important. See instructions on back of certificates.

D 58134

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 ✓ D 58134

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 113 Hawthorn Road 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Georgia A. Duvall

(Residence in Baltimore: No. 113 Hawthorn Road St.; 80 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 14 (Day), 1838 (Year)

7 AGE: 88 yrs. 5 mos. 13 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Aaron Duvall

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth A. Sheppard

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. S. Wise

(Address) 113 Hawthorne Road

15

1 29 1921

Robert P. Harrison, , 191

Burial Permit Clerk. REGISTRAR

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that it may be properly classified.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 28 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 192[illegible] to Oct 28, 1921, that I saw h[illegible] alive on Oct 27, 1921, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Ch. Valvular Heart

(Duration) [illegible] yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Milner Hodgdon M.D.

Oct 29, 1921 (Address) 750 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount — DATE OF BURIAL: Oct 29, 1921

20 UNDERTAKER: John O'Mulvihill — ADDRESS: 1201 N. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58135

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 S. Bond ST.; 3 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Janina Lapinski

(Residence in Baltimore: No. 632 S. Bond St.; 1 yrs., 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	X

6-DATE OF BIRTH, Aug 10, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Bronislaus Lapinski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Mary Pietrowiak

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bronislaus Lapinski

(Address) 632 S. Bond

15- Robert P. Harrison,
Burial Permit Clerk
Registrar.
OCT 29 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27 1921, to Oct. 28 1921, that I saw her alive on Oct. 28 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) /

(Duration) yrs. mos. ds.

(Signed) John H. Rehberger M. D.

Oct. 29, 1921. (Address) 1709 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Oct. 30, 1921
20-UNDERTAKER	ADDRESS
John J. Weber	803 Bank St.

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 58136 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital ST., 10 WARD)

REGISTERED NO. 1770

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank A. Hunder

(a) RESIDENCE NO. 339 S. Fulton ST. St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14th 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush 286

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John Hunder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Rottenziger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chicago

14 Informant Mrs. Jas. Hunder
(Address) Lyndenow Md

15 Filed 29 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 26, 1921, to Oct. 28, 1921, that I last saw him alive on Oct 28, 1921, and that death occurred, on the date stated above, at 3:45 a/m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) H. V. Harper M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 31st 1921

20 UNDERTAKER	ADDRESS
F B Keppert	2236 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58137 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 58137

H 6

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 919 Cathedral St (St.) 11 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Heberton Evans.

(a) RESIDENCE. No. 919 Cathedral St (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary V. C. Evans

6 DATE OF BIRTH (month, day, and year): April 7 1857

7 AGE: Years 62 Months 6 Days 6 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Charles D. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Ann Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa

14 Informant: Mary V. C. Evans

(Address) 919 Cathedral St

15 Filed Nov 1st 1921 Robert E. Martinson Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1921, to Oct 28, 1921, that I last saw him alive on October 27, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Henry J Jenkins, M. D.

(Address) 73 W Franklin

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Oct 31 1921
20 UNDERTAKER	**ADDRESS**
Henry J Jenkins & Sons Co	Orchard & McCulloh Sts

CAUSE OF DEATH on back of certificate.
TION is very important. See instructions on back of certificates.

29 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58138 D 58138

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Hanover St. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Keyser

(a) RESIDENCE. No. 1504 Hanover St. 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or wife of)~~ Ellen E Keyser

6 DATE OF BIRTH (month, day, and year) March 28 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardwood

(b) General nature of industry, business, or establishment in which employed (or employer) Finisher odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER C. Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ellen E Keyser

(Address) 1504 Hanover St

15 Robert P. Harrison,

Registrar

Burial Permit Clerk

2 9 1921

CAUSE OF DEATH in plain terms. So that it may be TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 . 1921 . to Oct 27 . 1921 . that I last saw h e alive on Oct 27 . 1921 . and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uremia

CONTRIBUTORY (Secondary) Chronic Brights (duration) — yrs. — mos. 3 ds.

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A Kurtzenberg, M. D.

, 19 (Address) 1340 St Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lounden Pk Cem	March 29 1922

20 UNDERTAKER Mrs J E Evans & Son ADDRESS 1420 E Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58139

HEALTH DEPARTMENT—CITY OF BALTIMORE

1766 D 58139

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) 23 (Ward)

2-FULL NAME Mr. Theodore Owings

(a) RESIDENCE. No. 115 N. Clement St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of — Mrs. — Owings

6 DATE OF BIRTH (month, day, and year) Oct 9 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sergeant 3rd

(b) General nature of industry, business, or establishment in which employed (or employer): Balto Police

(c) Name of employer: Depty Prisn Comd

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: James Owings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jennie Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mercy Hospital Catherine St

15 Filed Robert P. Harrison Registrar

OCT 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1921, to Oct 28, 1921, that I last saw him alive on Oct 28, 1921, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 22 1921

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) John F. Erbon Jr. M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Oct 31 1921
20 UNDERTAKER	ADDRESS
John F Denny	715 L. St

Information should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58140 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58140

100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2634 E. Oliver ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian M. Siebert

(a) RESIDENCE. NO. 2634 E. Oliver ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3/1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Fred. J. Siebert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Fred. J. Siebert (Address) 2634 E. Oliver

15 Filed 2 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1921, to Oct. 28, 1921, that I last saw h[illegible] alive on " 27, 1921, and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic tonsillitis

(duration) yrs. unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

(Address) 2214 Maryfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Can.	Oct. 31, 1924
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

CAUSE OF DEATH to plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58141

D 58141

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 E. Hoffman ST.; 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John George Vogel

(Residence in Baltimore: No. 2309 E. Hoffman St. St.; 35 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~SINGLE~~ MARRIED, ~~WIDOWED, OR DIVORCED.~~ (Write the word.) married

6-DATE OF BIRTH, August (Month) 18 (Day), 1867 (Year)

7-AGE, 54 yrs. 2 mos. 9 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Bavaria Ramerg

PARENTS.

10-NAME OF FATHER, John G. Vogel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Schmitt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Vogel (Brother)

(Address) 132 S. East Ave.

15-

Robert P. Harrison,

Filed ..., 191... Registrar.

T 2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 27 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23 1921, to Oct. 27 1921, that I saw him alive on Oct. 27 1921, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis acute

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Atrophia of the Liver

(Duration) ... yrs. 2 mos. ...

(Signed) F. J. Lebold M. D.

Oct. 27, 1921 (Address) 1001 Orleans St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL, OR REMOVAL, Schwartz Cem. DATE OF BURIAL, Oct. 30, 1921

20-UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 58142 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58142

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Holbrook ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine. M. Hayne

(a) RESIDENCE NO. 1211 Holbrook ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 28 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mrs. John Dillman
(Address) 1268 Holbrook

15 Filed OCT 29 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1921

17

I HEREBY CERTIFY, That I attended deceased from 10/25, 1921, to 10/28, 1921, that I last saw h[illegible] alive on 10-28, 1921 and that death occurred, on the date stated above, at 7[45] P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis
unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of Lung
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Wells, M. D.
1929. 1921 (Address) 9 E & E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 31 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

CT 29 1921

CAUSE OF DEATH in plain terms, so that it may be intelligible to the Bureau of Vital Statistics. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58143

CERTIFICATE OF DEATH.

REGISTERED NO. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 230 Rock (St.) | 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Green

(a) RESIDENCE. NO. 230 Rock ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, 16 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Charles Green

11 BIRTHPLACE OF FATHER (city or town) Birmingham (State or country) Alabama.

12 MAIDEN NAME OF MOTHER Cora Nadey

13 BIRTHPLACE OF MOTHER (city or town) Lancaster (State or country) Virginia.

14 Informant (Address) UNIVERSITY OF MARYLAND.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1921, to ..., 1921, that I last saw him alive on October 24, 1921, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Umbilical Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Premature separation of cord

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. J. Tigrey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health,

ADDRESS, OCT 28 1921

Per. Wm. E. WOODALL

CAUSE OF DEATH must be filled in. Every question must be answered. Write plainly with ink. Use no abbreviations. Do not use ditto marks. Make no erasures. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58144

CERTIFICATE OF DEATH.

154 D 58144

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Sherwood Hotel St.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Almirah Jacobs.

(a) RESIDENCE. NO. Sherwood Hotel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced (write~~ the word): Widow

5a If married, widowed, ~~or divorced~~ ~~(Write Name)~~ (or) WIFE of Barton Richmond Jacobs

6 DATE OF BIRTH (month, day, and year) Dec 9 1828

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of Industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Norwell
(State or country) Plymouth Co. Mass

PARENTS

10 NAME OF FATHER Ford.

11 BIRTHPLACE OF FATHER (city or town) Plymouth Co
(State or country) Mass

12 MAIDEN NAME OF MOTHER Almirah Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Norwell
(State or country) Mass

14 Informant Dr Hy Barton Jacobs
(Address) 9 East Vernon Place

15 Filed OCT 29 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1921, to Oct 28, 1921, that I last saw h[illegible] alive on Oct 28, 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary edema

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 97 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) H Warren Buckler M. D.

. 19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norwell - Mass

DATE OF BURIAL: 10-29 19[illegible]

20 UNDERTAKER: Howard Jenkins Co

ADDRESS: McCulla Orchard

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58145 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58145

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2010 McCulloh ST.: 14 WARD)

2-FULL NAME George W. S. Boothe

(a) RESIDENCE. NO. 2010 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 0-70

(b) General nature of industry, business, or establishment in which employed (or employer) Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Boothe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Laura Taylor (Address) 2010 McCulloh Street

15 Filed Robert P. Harrison, Registrar

2 9 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th. 1921. to Oct 26th. 1921. that I last saw h~~im~~/alive un Oct 26th. 1921. and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duratiun) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Only Symptoms

(Signed) W. Grant Foth. M. D.

. 19 (Address) 364 N. Biddle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct. 29 192
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Ellwig St.

CAUSE OF DEATH to be filled in plainly. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58146

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 Cumberland ST.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Ellsworth. Eareckson jr.

(a) RESIDENCE. NO. 723 Cumberland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Milton E. Ereckson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Lulu Wentz.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant (Address) Mrs Lulu E Ereckson 723 Cumberland St.

15 Filed 10-29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to Oct 28, 1921, that I last saw him alive on Oct 26, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus OVER

(duration) — yrs. 7 mos. 30 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General symptoms

(Signed) Charles E. Clarke, M. D.

10-28 1921 (Address) 1306 W. Fremont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 29 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schwab	201 Fredk. Ave

CAUSE OF DEATH to be given on back of certificates. ATION is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Mother had to go out to work and could not get help/attention should have had. Had attack of intestinal indigestion at week before death. Marasmus probably due to lack of attention

D 58147 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58147

CERTIFICATE OF DEATH. X 172

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2111 W Baltimore St. 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2 FULL NAME Isadore Howard

(Residence in Baltimore: No. 2111 W Baltimore St

St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov (Month) 24 (Day), 1862 (Year)

7-AGE, 58 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Jackson

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. P. Iverson

(Address) 2111 W. Balto St

15- Filed ....., 191.... Registrar.

Robert F. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture Arm & Internal injuries from falling down Stairs

(Duration) ....yrs. ....mos. 1/2 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. 4h ds.

(Signed) James M Gruber (Coroner.) M. D.

Oct 28 1924 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Berkely - Va	Oct 30, 1924

20-UNDERTAKER Wm Hickmerson ADDRESS North & P

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

OCT 29 1924

Spec.—8-24-14—M. & T.—2000 Bks.

Malone

58147 D 58148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 58147 D 58148

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3167 Elmora Ave ST. 96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Malone

(Residence in Baltimore: No. 3167 Elmora Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, ... (Month) 4 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. 7 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None .....

9-BIRTHPLACE, (State or Country), Baby Md

PARENTS.

10-NAME OF FATHER, Leroy Malone

11-BIRTHPLACE OF FATHER (State or Country), Baby Md

12-MAIDEN NAME OF MOTHER Mary Augusta Strobel

13-BIRTHPLACE OF MOTHER (State or Country), Baby Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leroy Malone

(Address) 3167 Elmora Ave.

15-

OCT 30 1921

Filed ..... 191.....

ROBERT P. KRAUTH

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1921, to Oct 24 1921, that I saw h[illegible] alive on Oct 24 1921, and that death occurred, on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

..... Spasm Bronchial Pneumonia .....

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY ..... None .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) ..... M. D.

10/27, 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Schwartz Lee Trapp	Oct 27, 1921
20-UNDERTAKER	ADDRESS
Frank A. Fink	905 N. Gay St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58149 HEALTH DEPARTMENT—CITY OF BALTIMORE 58149

CERTIFICATE OF DEATH.

79 D 58149

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 E. Federal ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Burke

(a) RESIDENCE. No. 2008 E Federal ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T. Burke

6 DATE OF BIRTH (month, day, and year) Aug 8 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dallo Md

PARENTS

10 NAME OF FATHER William Shaney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rosanna Moan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dallo Md

14 Informant Hanna Burke

(Address) 2008 E. Federal St

OCT 3 01921

ROBERT I. KRAJILA Registrar

Social Family Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1921, to Oct 29, 1921, that I last saw h[illegible] alive on Oct 28, 1921, and that death occurred, on the date stated above, at 12,50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? None.

What test confirmed diagnosis? None

(Signed) D S Herzog MD M. D.

Oct 29 1921 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Cemetery (Govans)	Oct 31 1921
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1938 E. Lafayette Ave.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 581308 HEALTH DEPARTMENT—CITY OF BALTIMORE D 581308

CERTIFICATE OF DEATH.

79

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Brunt ST., 14 WARD)

2-FULL NAME George Jane

(a) RESIDENCE No. 2018 Brunt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Jane

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 035

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Richard Jane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cabot Co Md.

12 MAIDEN NAME OF MOTHER Harriett Whiting

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cabot Co Md.

14 Informant Emma Jane
(Address) 2018 Brunt St

15 Filed OCT 30 1921 ROBERT I. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1921, to Oct 26, 1921, that I last saw h[illegible] alive on Oct 26, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

Oct 26, 1921 (Address) 1928 E Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Samuel Cemetery

DATE OF BURIAL Oct 30 1921

20 UNDERTAKER Felix B Pyle

ADDRESS 102 E. Mulberry

CAUSE OF DEATH to be plainly written, and all questions answered. Information on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D58150 D58151

HEALTH DEPARTMENT—CITY OF BALTIMORE D58151

CERTIFICATE OF DEATH.

X 146

1-PLACE OF DEATH Balto Eye, Ear & Throat Hosp. 13

CITY OF BALTIMORE: (No. 625 W. Franklin ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Kullberg

(a) RESIDENCE. No. Georgian Apts. ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	0	00	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs Theo-Eisner

9 BIRTHPLACE (city or town) (State or country) Providence R I

PARENTS

10 NAME OF FATHER Ferdinand Kullberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Maria Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Mrs Theo-Eisner
(Address) Georgian Court Apts

15 OCT 30 1921 ROBERT J. BRYER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1921, to Oct. 29, 1921, that I last saw her alive on Oct. 29, 1921, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Mastoiditis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebellar Abscess

(duration) yrs. 20 mos. ds.

18 Where was disease contracted if not at place of death? Providence R. I.

Did an operation precede death? Yes Date of 9/22/21

Was there an autopsy? No. 10/23/21

What test confirmed diagnosis? Operations

(Signed) J. C. Thomas M. D.

Bel Air Eye, Ear & Throat Hosp. 1921 (Address) 625 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Providence R.I.	Oct 30th 1921

20 UNDERTAKER David Sondheim ADDRESS 1188 W Baltimore St

CAUSE OF DEATH ... on back of certificates. See instructions on back of certificates. TION is very important.

Spec.–1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58152

CERTIFICATE OF DEATH.

80 D 58152

1-PLACE OF DEATH Forrest Park

CITY OF BALTIMORE: (No. 3614 Springdale Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Cohen

(a) RESIDENCE NO. 3614 Springdale Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harris Cohen

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J Lewis

(Address) 1411 E Balt St

15 Filed OCT 30 1921 DOROTHY B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to Oct. 28, 1921, that I last saw her alive on Oct. 28, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Cohen M. D.

Oct 29, 1921 (Address) 2235 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Shalom DATE OF BURIAL 10/30/1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balt St

CAUSE OF DEATH to be plainly written. Consult Physician and Undertaker before filling out certificates. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58153

CERTIFICATE OF DEATH

91 D 58153
REGISTERED NO. C

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Fannie Rosenblatt

(Residence in Baltimore: No. 1127 E 20th St St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	married

6-DATE OF BIRTH ..... (Month) ..... (Day), 1893 (Year)

7-AGE, 28 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Baltimore St

15- OCT 30 1921 Filed ..... 191.. ROBERT J. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Oct 29 1921, that I saw her alive on Oct 28 1921, and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Final

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) ..... M. D.

10 29, 1914. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 28 ds. In the State 10 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1127 E 20th St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Int Carmel — DATE OF BURIAL, 10/30, 1921.

20-UNDERTAKER Jack Louis — ADDRESS 1411 E Baltimore St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58154

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

2-FULL NAME Wm. K. Hagan

(a) RESIDENCE. NO. Homestead Rd ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Effie

6 DATE OF BIRTH (month, day, and year) June 16, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Hagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Nora Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 [illegible] OCT 30 1921 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-25 , 192 , to 10-29 , 1921 ,

that I last saw him alive on 10-29 , 1921 ,

and that death occurred, on the date stated above, at 11.57 p m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency .

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic endocarditis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Maryland

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) John L. Lansey , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampstead Md. DATE OF BURIAL 10/30/21

20 UNDERTAKER W J Perkins & Son ADDRESS Penna Rd

NO. is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58155

CERTIFICATE OF DEATH.

47 D 58155

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Little Sisters of the Poor (ST.) 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Stallings.

(a) RESIDENCE. No. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Stallings

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	abt 72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co, Md.

PARENTS

10 NAME OF FATHER Joseph Grasshammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Seffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence, (Address) Preston & Valley.

15 Filed OCT 30 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 8 Record, 19 , to , 19 ,

that I last saw her alive on Oct 23, 1921,

and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vulva

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warner, M. D.

Oct 29. 1921 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
R. M. E. Cemetery. Reisterstown	Nov 1 1921

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

TION is very important. See instructions on back of certificates.

Spec—6-9-19—H. P. Co.—1000 Blks.

1571 B 92 58156

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-09 V D 58156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Primo Amati

(a) RESIDENCE NO. 737 Harford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-23-05

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass

PARENTS

10 NAME OF FATHER Frank Amati

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Lennie Pinnini

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 OCT 3 01921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-13, 1921, to 10-29, 1921, that I last saw h[illegible] alive on 10-29, 1921, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. mos. 46 ds.

CONTRIBUTORY (Secondary) Pneumonia (lobar? left upper?)

(duration) yrs. mos. 2. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) C. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 31 1921
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave.

TION is very important. See instructions on back of certificates.

Spec.—S 24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58157

CERTIFICATE OF DEATH.

D 58157

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Bond ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas F. O'Brien

(Residence in Baltimore: No. 1501 N. Bond St. St.; Lifetime yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month), (Day), 1 (Year)

7-AGE, 60 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Commission
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Wm H. O'Brien

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Hannah Scanlon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Daniel Bairn

(Address) 1501 N. Bond St

15- Filed OCT 30 1921, 191.... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 30 1921, to Oct 28 1921, that I saw h[illegible] alive on Oct 28 1921, and that death occurred, on the date stated above, at 11 7 m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia 4 months 28 days

Rt Hemiplegia 4 days

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) 2 yrs. 3 mos. ....ds.

(Signed) [illegible] M. D.

Oct 29, 1921 (Address) 1038 N. Broadway

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, Oct 31, 1921

20-UNDERTAKER Chas S. Ware & Son — ADDRESS 115 W. Mt Royal Ave

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58158

D 58158

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Boyle St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jacob Graf

(a) RESIDENCE. NO. 1435 Boyle St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male n	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie B. Graf

6 DATE OF BIRTH (month, day, and year) Jan. 23 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cooper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Graf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Leibold (Address) 1435 Boyle St.

15 FILED OCT 3 01921 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9 1921 to Oct. 29 1921, that I last saw him alive on Oct. 28 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Right Hemiplegia)

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Irvin Ebaugh M. D.

Oct 30 1921 (Address) 701 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — DATE OF BURIAL: 11/1 1921

20 UNDERTAKER: J. F. McCully — ADDRESS: 130 E. Fort

TION is very important. See instructions on back of certificates.

Sinn.—6-9-19—H. P. Co.—1000 Blks.

Tiernan

D 58159

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58159

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST. 124 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Tiernan

(a) RESIDENCE No. 1231 Hanbert Pl ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3 - 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Martin Tiernan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Agnes Mattimore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. Records.
(Address)

15 Filed OCT 3 0 1921 19 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 28 1921

17 I HEREBY CERTIFY, That I attended deceased from 10 - 27, 1921, to 10 - 28, 1921, that I last saw h[illegible] alive on 10 - 28, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Primary)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Loane

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

10/27, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 10/31 1921

20 UNDERTAKER: S. Few McCully

ADDRESS: 130 E. Fort

TION is very important. See instructions on back of certificates.

D 58160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 D 58160

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No 623 N. Robinson ST. 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Carrie Ruby Davis

(Residence in Baltimore: No. 623 N. Robinson St. 34 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 26, 1888 (Month) (Day) (Year)

7 AGE: 33 yrs. 7 mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: J. W. Wilson

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ann Fritz

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry A. Davis

(Address) 623 N Robinson St

15 OCT 3 01921 Filed ....., 19.. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 29, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921, to Oct 29, 1921, that I saw h[illegible] alive on Oct. 28, 1921, and that death occurred, on the date stated above, at 5.30 p m.
The CAUSE OF DEATH* was as follows:

Pernicious Anaemia & Valvular Heart Disease Mitral Regurgitation

(Duration) ... yrs. 5 mos. ds

Contributory (SECONDARY) Wm Grant

(Duration) ... yrs. ... mos. 15 ds.

(Signed) Wm Grant M. D.

..... 191 (Address) 2226 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Oaklawn Cem — DATE OF BURIAL: Nov 1 ....., 1921

20 UNDERTAKER: Robert Brookerson — ADDRESS CALHOUN HOLLINS

N. B.—Every item of information must be given as accurately as possible. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58161

CERTIFICATE OF DEATH.

28 D 58161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 W. Lee ST., 27 WARD)

2-FULL NAME Samuel D. Goldberg.

(a) RESIDENCE NO. 130 W. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Goldberg

6 DATE OF BIRTH (month, day, and year) Nov 22, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	11	7	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work manufacturer

(b) General nature of Industry, business, or establishment in which employed (or employer) Pants.

(c) Name of employer

9 BIRTHPLACE (city or town) Town (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon H. Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Miriam Hammon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Annie Goldberg

(Address) 130 W. Lee St

15 OCT 30 1921 ROBERT J. CRAWFORD Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct, 13, 1921, to Oct, 29, 1921, that I last saw him alive on Oct, 29, 1921, and that death occurred, on the date stated above, at 1 P, m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Hemmorhage

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Findings

(Signed) Dan Drancin, M. D.

10/29 1921 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Cem

DATE OF BURIAL Oct 30 1921

20 UNDERTAKER Sol Levinson Bro

ADDRESS 1127 E. Baltimore St

CAUSE OF DEATH on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Leopold. Tramer

D 58162 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 58162

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopold Tramer

(a) RESIDENCE. No. 2114 N. Pulaski St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Rosa Tramer

6 DATE OF BIRTH (month, day, and year) Feb 15 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oculist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Jacob Tramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant E. Tramer

(Address) 2114 N Pulaski St

15 OCT 30 1921 SCOTT I KRAUTH Registrar

Burial Permit Oct 30

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1921, to Oct 29 1921,

that I last saw h.. alive on Oct 29 1921,

and that death occurred, on the date stated above, at 12:15 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typ Symptoms

(Signed) J. W. Taylor, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	Oct 30 1921
20 UNDERTAKER A. Garrison + Bro	ADDRESS 1127 E. Balto St

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58163 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58163

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Royal & Lafayette Aves St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rt. Rev. Monsignor Willian E. Starr

(Residence in Baltimore: No. Mt. Royal & Lafayette Aves. St.; 80 yrs., 10 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, December (Month) 24 (Day), 1840 (Year)

7-AGE, 80 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Priest 018
(b) General nature of industry, business, or establishment in which employed (or employer)..... Roman CatholicChr

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. J. A. Smith

(Address) Mt. Royal & Lafayette Aves.

15-

Filed OCT 30 1921 ROBERT J. KRAUTH Registrar of Vital Statistics

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1919, to Oct. 26 1921, that I saw h[illegible] alive on Oct. 26 1921 and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myo-Carditi[illegible]
with general Arteriosclerosis

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY Acute Cardiac Dilatation
(Secondary) Pneumonia Plus,

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Cheverus M. D.

Oct 27, 1921 (Address) 804 Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	10/31, 1921
20-UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58164

CERTIFICATE OF DEATH.

9-091

D 58164

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Majagazinier.

(a) RESIDENCE. NO. 3401 Greenmount Ave WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 20-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Majagazinier.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Rose Jozingik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis Hill E. Balto St

15 Filed OCT 30 1921 19 ... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1921, to Oct 29, 1921, that I last saw him alive on Oct. 29, 1921, and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) B Macgowan, M. D.

, 19 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Northern Cemetery	10/30 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto St

CAUSE OF DEATH on page—See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58165

D 58165

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1206 Whitecoat ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie O'neil

(a) RESIDENCE. NO. 1206 Whitecoat ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Dec 26 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
45	10	1.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Danville Va Virginia

PARENTS

10 NAME OF FATHER James Bruce

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Pore Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Danville Virginia

14 Informant (Address) John Holland. 1354 Whitecoat St.

15 OCT 30 1921 [illegible] Registrar. Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 26 1921 to Oct 27 1921, that I last saw h[illegible] alive on Oct 27 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) — yrs. — mos. One ds.

CONTRIBUTORY (Secondary) Excessive Alcoholism

(duration) — yrs. — mos. 20 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) Charles E. Clark, M. D.

10-28 1921 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct. 30 1921
20 UNDERTAKER James L. Dennis	ADDRESS 1303 Gilmor

TION is very important. See instructions on back of c[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58166

CERTIFICATE OF DEATH.

63 D 58166

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.; 10 WARD)

2-FULL NAME Mary Ellsworth Wagner

(a) RESIDENCE. No. Preston Valley St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of E. Harry Wagner

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown	86	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Thomas Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ann Dougherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Sister Florence, Supr
(Address) Preston Valley St

15 Filed . 19 [illegible] Registrar
OCT 3 01921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17 I HEREBY CERTIFY, That I attended deceased from No record . 19 . to . 19 .

that I last saw her alive on Oct 28 . 1921 .

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute bulbar Paralysis

about 1 mo (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Oct 28 1921 (Address) 1133 Valley st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	Oct 31 1921
20 UNDERTAKER William Cook	ADDRESS 502 E North

CAUSE OF DEATH. See instructions on back of certificates. ATTENTION is very important.

Spec. 6-9-19 — P. Co. — 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58167

15/535 58167 D 58167

CERTIFICATE OF DEATH.

X 74 D 58167

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hannah Bernstein

(a) RESIDENCE. NO. Athens, Georgia ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Selig Bernstein

6 DATE OF BIRTH (month, day, and year) 1-23-67

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C

PARENTS

10 NAME OF FATHER Emanuel Siemens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 OCT 3 01921 [redacted] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-25, 1921, to 10-30, 1921, that I last saw h e alive on 10 30, 1921, and that death occurred, on the date stated above, at 5-07 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Operation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt. Kenwan.

Did an operation precede death? Yes Date of 10/29/21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Dr. Emil Ochsner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Athens Ga. DATE OF BURIAL: 10/31 1921

20 UNDERTAKER: Land Boardman Hebrew Rep

ADDRESS

CAUSES OF DEATH. See instructions on back of certificates. TION is very important.

Print.—6-9-19—H. P. Co.—1000 Bks.

58168

HEALTH DEPARTMENT—CITY OF BALTIMORE

58168 D 58168

64 D 58168

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1116 Hope Retreat St. N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Under Maryland Emergency

(a) RESIDENCE. No. 1116 Hope Retreat St., 5 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher ret'd

(b) General nature of industry, business, or establishment in which employed (or employer) Teaching

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark Ohio

PARENTS

10 NAME OF FATHER Noah P. Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elizabeth Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Friends 1116 Hope Retreat St
(Address) Baltimore Md

15 FILED OCT 30 1921 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6. 1920 to Oct. 30. 1921.

that I last saw h alive on Oct. 9. 1921.

and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

About 2 (duration) — yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

30 Yrs (duration) 30 yrs. — mos. — ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas. R. Hill, M. D.

19 (Address) 1116 Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkersburg - W. Va	Oct 30 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)	ADDRESS 106 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58169

CERTIFICATE OF DEATH.

28 D 58169

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Anderson

(a) RESIDENCE No. 1113 N. Dallas St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Office

(b) General nature of industry, business, or establishment in which employed (or employer): Minor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Abingdon Harford County, Md.

12 MAIDEN NAME OF MOTHER: Carrie Peaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Edgewood Harford County, Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL Baltimore

15 Filed OCT 31 1921 19 [redacted] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1921, to Sept. Oct. 27, 1921, that I last saw her alive on Oct. 27, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Less than 3 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray - Intestinal tuberculosis

(Signed) F. H. Mocch, M. D.

, 19 (Address) Harriet Lane Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemetery	Oct 31 1921
20 UNDERTAKER	ADDRESS
John H Clemens	538 Dolphin St

CAUSE OF DEATH. Physician's attention to this item is very important. See instructions on back of certificate.

D 58170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58170

CERTIFICATE OF DEATH.

175,001

1-PLACE OF DEATH Camden Yard. REGISTERED NO. C

CITY OF BALTIMORE (No. B. & O.R.R. tracks near West St. / ST. St. / WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis H. Dietz.

(Residence in Baltimore: No. 1216 Patapsco St.

59 yrs., 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, September 17th, 1862, / (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
59 yrs. 1 mos. 10 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Track cleaner 073
(b) General nature of industry, business, or establishment in which employed (or employer)..... B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Conrad Dietz.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Dietz. (wife)

(Address) 1216 Patapsco St.

Filed....., 191.... Burial Permit Dist. Registrar.

BOWEN & BEAUTY

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27th, 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock & Hemorrhage. Crushed about the lower extremities. Occidentally run over by Engine #1434 of B. & O. R. R. Company..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds.

(Signed) H. W. Leonard M. D. (Coroner.)

Oct. 28th, 1921. (Address) 10 W. S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross A&C	10-31, 1921

20-UNDERTAKER	ADDRESS
E. T. B. Hale	115 E. North Ave

CAUSE OF DEATH must be plainly written. Every question must be answered if possible. Omissions cause unnecessary delay. Information is important. See instructions on back of certificate.

D 58171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58171

CERTIFICATE OF DEATH.

REGISTERED No. C 192

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 37 E. Hughes St. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Skinner. (C)

(Residence in Baltimore: No. 37 E. Hughes St. 61 St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH, Do not know. (Month), / (Day), (Year)

7-AGE, 61 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Carpenter. (C)

(Address) 37 E. Hughes St.

15- OCT 31 1921 191.... [illegible] Registrar.

Burial Permit Issued

CAUSE OF DEATH in plain terms so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto R. Leonhardt M. D.
(Coroner.)

Oct. 30th. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Oct. 31, 1921

20-UNDERTAKER John H. Trading — ADDRESS 142 Uhrill St

Spec.—6-9-19—H. P. Co.—1000 Bks.

William Kratz Gebhardt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58172

CERTIFICATE OF DEATH.

189 D 58172

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 417 S Smallwood St.; 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kratz

(a) RESIDENCE. No. 417 S Smallwood St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER William Kratz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Freda Gebhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Freda Gebhard

(Address) 417 S Smallwood St

15 OCT 31 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1921, to Oct 29, 1921, that I last saw alive on Oct 28, 1921, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Norbert A. Kitsch, M. D.

Oct 30 1921 (Address) 2151 Mulberry Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	OCT 31 1921
20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1535 W. PRATT STREET	ADDRESS

CAUSE OF DEATH. Physician must fill in answers to all questions. Filling in dates, ages and technical words is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58173

CERTIFICATE OF DEATH.

D 58173

REGISTERED NO. 1921 091

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St. Joseph's Hospital (St.) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gibbrich (Gipprich)

(a) RESIDENCE. No. 705 S. Monford Ave (St.) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Gipprich

6 DATE OF BIRTH (month, day, and year) June 24 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

11 Informant Rev. John Gipprich S.J. (Address) Georgetown College D.C.

15 OCT 31 1921 [illegible] Registrar

CAUSE OF DEATH must be entered plainly. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from October 21 1921, to October 28, 1921, that I last saw her alive on October 28, 1921, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. and S.

(Signed) Frank C. Marino M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct. 31 1921
20 UNDERTAKER	ADDRESS
Lilly & Feiler.	403 S. Wolfe

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58174

CERTIFICATE OF DEATH.

137 D 58174

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Ellwood Ave. ST.: 1st. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Elizabeth Griffith

(a) RESIDENCE No. 802 S. Ellwood Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

3a If married, ~~widowed, or divorced~~ ~~(H) (She's Dead)~~ (or) WIFE of: Charles Wesley Griffith

6 DATE OF BIRTH (month, day, and year): Nov 13, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): assist in housework

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Denton Maryland

PARENTS

10 NAME OF FATHER: Ira Frank Willoughby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denton Md. {?}

12 MAIDEN NAME OF MOTHER: Zora Collison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Denton Md. {?}

14 Informant: Charles W. Griffith
(Address) 802 S. Ellwood Ave.

15 Filed: OCT 31 1921

Burial ~~is~~ illegible

CAUSE OF DEATH to be plain terms, so that it may be readily understood. Do not use abbreviations or technical terms. Carefully read the questions on back of certificates. ATTENTION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to Oct 28, 1921, that I last saw her alive on Oct 28, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Convulsions, 1 hour

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? removal of retained secundine Date of Oct 26

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. V. M. Wright, M. D.

Oct 28 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Oct 31. 1921
20 UNDERTAKER: John Purvis & Co	ADDRESS: 2008 Aliceanna

Spec.—6-9-19—H. P. Co.—1000 Bks.

58175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 58175

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 936 W: Mulberry St (ST.:) 18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise W: Schmidt.

(a) RESIDENCE. NO. 936 W: Mulberry ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schmidt

6 DATE OF BIRTH (month, day, and year) Dec 29 th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Farber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Schmidt

(Address) 936 W: Mulberry St

15 Filed OCT 31 1921 . 19 [illegible] Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 — 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct - 19 , 1921 , to Oct 28 , 1921.

that I last saw h~~er~~ alive on Oct 28 , 1921.

and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Coma —

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 31 1921
20 UNDERTAKER	ADDRESS
John Herwig & Co	2008 Orleans

John

CAUSE OF DEATH in plain terms, stating the disease and not the symptoms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58176

CERTIFICATE OF DEATH.

154 D 58176

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Calvert Court Apartment ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edwin Clark

(a) RESIDENCE. No. Calvert Court Apartments ST., 12 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 95 yrs. 10 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Clark

6 DATE OF BIRTH (month, day, and year) December 17-1825

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	95	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant.

(c) Name of employer (Self) Portland

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Amysel Clark

11 BIRTHPLACE OF FATHER (city or town) Lebonon (State or country) Conn.

12 MAIDEN NAME OF MOTHER Sallie Simms

13 BIRTHPLACE OF MOTHER (city or town) Libonon (State or country) Conn.

14 Informant Mrs. J. F. Voskell (daughter)

(Address) Calvert Court Apts.

15 Filed OCT 31 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1921, to Oct. 29, 1921, that I last saw him alive on Oct. 29, 1921, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? usual symptoms

(Signed) Wm J. Dillsbury, M. D.

19 (Address) 415 Cedarcroft Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct 31 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58177

D 58177

CERTIFICATE OF DEATH.

REGISTERED NO. 69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Meeks

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Stepney
(State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md

15 Filed OCT 31 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1877 19 , to Oct 30 , 1921 ,
that I last saw him alive on Oct 29. , 1921 ,
and that death occurred, on the date stated above, at 7.30 A m.
The CAUSE OF DEATH* was as follows:

Epelepsy

Abt (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Epileptic Mania
Abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Harford Co Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 31 1921
20 UNDERTAKER STEWART & [illegible] (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Anna M. Kohler

HEALTH DEPARTMENT—CITY OF BALTIMORE

54

D 58178

CERTIFICATE OF DEATH.

D 58178

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Anna M. Kohler

(Residence in Baltimore: No. 2010 Mt. Royal Terrace. St.; 56 yrs., 1 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August (Month) 31 (Day), 1865 (Year)

7-AGE, 56 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Herman H. Buschman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Cramer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. Kohler Husband

(Address) 2010 Mt Royal Terrace

15-

DISTRICT | CERTIFICATE

Filed OCT 31 1921, 19..

Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) - 29 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-28 1921, to Oct-29 1921, that I saw h[er] alive on Oct-29 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia of Addison-Biermer Type

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. Lloyd Johnson M. D.

10-29, 1921 (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 1 mos. 0 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 2010 Mt Royal Terrace

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Nov - 2 -, 1921

20-UNDERTAKER STEWART & BROWN COMPANY (WILLIAM F. WOODEN, Successor).

ADDRESS 108 W. NORTH AVE.

important. See instructions on back of certificate.

D 58179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58179

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2130 Dukeland Way ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine M. Smith

(Residence in Baltimore: No. 339 Fairhill Ave. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH, March 6 (Month) (Day), 1857 (Year)

7-AGE.	If LESS than 1 day,
63 yrs. 11 mos. 10 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 0.37

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Eugene Muth

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Belz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Robert Gilden

(Address) Dukeland & Clifton Ave.

15- OCT 31 1921 191.... Burial Permit Issued Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia History

(Duration) yrs. mos. ds.

(Signed) J. T. Heffernan M. D. (Coroner.)

Oct 31 1921 (Address) 2807 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Oct. 31, 1921
20-UNDERTAKER	ADDRESS
Leitch & Son	1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hannibal

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58180

58180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Hannibal

(a) RESIDENCE. NO. 2018 Woolbworth ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank Hannibal Jr C

6 DATE OF BIRTH (month, day, and year) 18 Sept 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Reinhart Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Catherine Graff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Harry Hannibal 2018 Woolworth ave.

15 Filed OCT 31 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Oct 30 1921, that I last saw her alive on oct 30, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Flexure of Splenic Colon,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of oct 26 1921

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Henry C Warlick, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Nov. 2 1921
20 UNDERTAKER	ADDRESS
Josiah Tyler.	16 W 24th Nor ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO. D 58381

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Parkwood Ave ST.) 13 WARD)

2-FULL NAME Harry W. Gosnell

(a) RESIDENCE. No. 2823 Parkwood Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. X mos. X ds. How long in U. S., If of foreign birth? ~~X~~ yrs. ~~X~~ mos. ~~X~~ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Fannie Gosnell

6 DATE OF BIRTH (month, day, and year) May 23-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or X min.
	51	5	6	X

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Purchaser & 186
(b) General nature of industry, business, or establishment in which employed (or employer) Millinery
(c) Name of employer Armstrong Cator Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Luther Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catharine Allidge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Fannie Gosnell
(Address) 2823 Parkwood ave.

15 Filed OCT 31 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from 5/24, 1921, to 10/29, 1921, that I last saw h~~im~~alive on 10/29, 1921, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis and a general tuberculor condition of Glands.
(duration) 17 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) X yrs. 1 mos. X ds.

18 Where was disease contracted if not at place of death? followed Pneumonia 1911

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) P. Bellison, M. D.

, 19 (Address) 1124 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvert	Oct 31 1921
20 UNDERTAKER	ADDRESS
Joseph Sykes	1601 N. North Ave

CAUSE OF DEATH must be filled in by the attending physician. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 58182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 E. Biddle ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Noonan

(a) RESIDENCE No. 1604 E. Biddle ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V. Noonan

6 DATE OF BIRTH (month, day, and year) June 5, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	68	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Noonan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Dunphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Emma V. Noonan (Address) 1604 E. Biddle St.

15 OCT 31 1921 ROBERT J. BRAUNE Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1921, to Oct. 26, 1921, that I last saw h in alive on Oct. 28, 1921, and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Schmitz, M. D.

Oct 30, 1921 (Address) 78 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov 2nd 1921
20 UNDERTAKER	ADDRESS
George Schulling & Sons	112 E. Madison St.

CAUSE OF DEATH in plain terms, so that a person not a physician may understand. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58183

CERTIFICATE OF DEATH.

150 D 58183

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Bull

(a) RESIDENCE. NO. 611 Harding Place ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-2-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Oliver Bull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Margaret Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

Filed OCT 31 1921 DOUGLAS H. GAUTIER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-19, 1921, to 10-29, 1921, that I last saw h[illegible] alive on 10-29, 1921, and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? yes Date of 10/25/21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Claude S. Beck, M. D.

, 19 (Address) John Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 30 1921
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut ave

CAUSE OF DEATH. If place of death was a hospital or institution, state whether patient was admitted from his own residence. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 58184

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 S.Ann ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Margaret Donn

(a) RESIDENCE. No. 236 S.Ann ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If ~~married~~, widowed, ~~or divorced~~
~~HUSBAND of~~
(or) WIFE of George W.Donn

6 DATE OF BIRTH (month, day, and year) Nov.7.1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Maryland

PARENTS

10 NAME OF FATHER William Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Maryland

14 Informant Mrs.John McWilliams
(Address) 236 S.Ann St.

OCT 31 1921

Buried from Chapel

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30.1921

17 I HEREBY CERTIFY, That I attended deceased from Oct-11-, 1921, to Oct-30-, 1921, that I last saw her alive on Oct-29-, 1921, and that death occurred, on the date stated above, at 10:00A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Old age

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William H. Johnson M. D.

10/31/1921 (Address) 2016 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington.D.C.	11-2-21 19

20 UNDERTAKER H.E.Hughes ADDRESS 424 N.Broadway

TION is very important. See instructions on back of certificates.

D 58185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

175 D 58185

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Burrier

(Residence in Baltimore: No. 4135 Falls Road St.; yrs. 54 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, April 28, 1870
(Month) (Day) (Year)

7-AGE, 57 yrs. 6 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paving 186
(b) General nature of industry, business, or establishment in which employed (or employer): Inspector

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Charles Burrier

11-BIRTHPLACE OF FATHER (State or Country). Frederick Co Md

12-MAIDEN NAME OF MOTHER. Annie McCullough

13-BIRTHPLACE OF MOTHER (State or Country). Washington D.C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine E. Burrier

(Address) 4135 Fall Road

15-

Filed ....., 191.... [illegible]

OCT 31 1927

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Lt leg

Auto (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm R Inskeep M. D.
(Coroner)

10-30-1927 (Address) U. S. Civil

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge 20-DATE OF BURIAL, ..., 19...

20-UNDERTAKER H. S. Marshall ADDRESS 3539 Fall Road

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58186

CERTIFICATE OF DEATH.

54 V D 58186

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Anna Brown

(Residence in Baltimore: No. 128 N. Exeter St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Jan 6 (Month) (Day), 1869. (Year)

7-AGE. 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Mr Kaun

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Mrs Kaun

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L Lewis

(Address) 1411 E Balto St

15- OCT 31 1921 191 L L G Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 31st. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5th. 1921, to Oct. 31st. 1921, that I saw her alive on Oct. 31st. 1921, and that death occurred, on the date stated above, at 4.25 A m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W Zinberg M. D.

10/01st, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. ds. In the State 20 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 128 N Exeter St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 10/31, 191..

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

Spec.—1-10-21—M&T—1500 Blks.

D 58187 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58187

CERTIFICATE OF DEATH.

79-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Low ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Silverman

(a) RESIDENCE NO. 1113 Low ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Silverman

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE: Years 25 | Months | Days | If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Jacob Kaplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mrs. Lewis 1411 E. Balto

15 Filed OCT 31 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1921, to Oct 30, 1921, that I last saw h-r alive on Oct. 30, 1921, and that death occurred, on the date stated above, at 9 05 P. m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis + insufficiency
auricular fibrillation

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Grant Leuhen, M. D.

Oct 31, 1921 (Address) 2350 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Henry Run — DATE OF BURIAL 10/31/1921

20 UNDERTAKER Jack Levin 1411 E Balto — ADDRESS

CAUSE OF DEATH must be written plainly in ink. See instructions on back of certificates. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 58188

REGISTERED NO.

D 58188

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 916 W Mulberry ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cyrus B Martin

(a) RESIDENCE. No. 916 W Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Martin

6 DATE OF BIRTH (month, day, and year) May 15th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 038

(b) General nature of industry, business, or establishment in which employed (or employer) Jeweler

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER David Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Jane Abrahis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lewes.

14 Informant Mrs. Ruth Martin (Address) 916 W Mulberry St.

15 Filed 19 Registrar

OCT 31 1921

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to October 30, 1921, that I last saw h— alive on October 30, 1921, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Nephritis chronic;

Nephritis interstitial - Chronic

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Microscopic Ex

(Signed) H Hamburger M. D.

10/31, 1921 (Address) 11 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Nov 2nd 1921
20 UNDERTAKER J J Cowan & Son	ADDRESS 901 Holliday St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58189

CERTIFICATE OF DEATH.

151 D 58189

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Westwood Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Theodore Muller.

(a) RESIDENCE NO. 1716 Westwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or terms which are not generally understood. Information required in items 16 to 20 is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29th 1921

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William H. Muller.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Loretta H. Dailey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant William H. Muller.

(Address) 1716 Westwood Ave.

15 Filed OCT 31 1921 J. E. Welsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1921, to Oct 29, 1921, that I last saw him alive on Oct 29, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth -

7 months - Weakness

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. Hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo H. Funk, M. D.

19 21 (Address) 1104 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 31" 1921

20 UNDERTAKER Wm J. Hartwell ADDRESS 2236 W. Baltimore St.

[illegible] 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58190

REGISTERED NO....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

149794
D 58190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 14 WARD)

2-FULL NAME Solomon Himmel

(a) RESIDENCE. NO. 2028 Eutaw Pl. ST.: WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19/1866

7 AGE: Years 55 54 | Months 2 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) of Jewelry Dft

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Moses L. Himmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Hannah Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Baltimore

15 Filed OCT 31 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921. to Oct. 29 1921. that I last saw him alive on Oct. 29, 1921. and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic bacterial endocarditis (streptococcus viridans.)

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture.

(Signed) V. H. Veeder M. D.

10-29, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fehr Brunsdorf DATE OF BURIAL: Oct 1 1921

20 UNDERTAKER: Lord & Sondheim ADDRESS: 118 W. Mt. St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58191 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58191

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Alhambra Apts ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Goldstein

(a) RESIDENCE. No. Alhambra Apts ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Goldstein

6 DATE OF BIRTH (month, day, and year) Sept 14 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg of Upholstered Furniture

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Abraham Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs Goldstein Alhambra Apts

15 Filed ..., 19... Registrar

OCT 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30" 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1921, to Oct 30, 1921, that I last saw h[illegible] alive on Oct 29 1921, and that death occurred, on the date stated above, at 6.15 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Seligman, M. D.

, 19 (Address) 1920 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Balto. Hebrew Cem. Nov 1st 1921

20 UNDERTAKER — ADDRESS

David Sondheim 118 W. Mt. Royal Ave

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

Pandor L. Cole. ✓

D 58192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091

REGISTERED NO. D 58192

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 W. Franklin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pandor Lawrester Cole

(a) RESIDENCE. No. 804 W. Franklin ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Calvert Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ester Montegue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) James E. Cole. 804 W Franklin St

15 FILED OCT 31 1921 ROBERT F. [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 29 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th, 1921, to Oct 29th, 1921, that I last saw her alive on Oct 29th, 1921, and that death occurred, on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 804 W Franklin St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jas C Carper, M. D.

. 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	10/31 1921
20 UNDERTAKER	ADDRESS
Julius B. Pyc	102 E. Mulberry St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97-078 D 58193

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 W Lanvale ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia F Seward

(a) RESIDENCE. NO. 1201 W. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W. Seward

6 DATE OF BIRTH (month, day, and year) March 6, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John L. Zwanziger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Frederick H Bruning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs John L. Zwanziger

(Address) 1201 W Lanvale St

OCT 31 1921

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1928, to Oct 28, 1921, that I last saw her alive on Oct. 28, 1921, and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Mai O'Neill, M. D.

10/28, 1921 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 31 1921
20 UNDERTAKER	ADDRESS
Harry H Witzke	1531 W Lanvale

TION is very important. See instructions on back of certificates.

D 58194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 58194

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1414 N. Vincent St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Dorsey

(Residence in Baltimore: No. 1414 N. Vincent St.; yrs., 34 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, November, 1882
(Month) (Day) (Year)

7-AGE, 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Hensey

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Julia ??

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Robertson

(Address) 941 Sarah Ann St.

15- OCT 31 1921

Filed ..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Heart disease

(Duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Oct. 31, 1921 (Address) 202 E. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Oct. 31, 1921

20-UNDERTAKER James H. Wemit

ADDRESS 1303 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

15 1480
D 58195
1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 D 58195
REGISTERED NO.

CITY OF BALTIMORE; (No. JOHNS HOPKINS HOSPITAL, ST.; 15 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Patterson.

(a) RESIDENCE. No. 1519 Pressman St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced, ~~HUSBAND of~~ ~~WIFE of~~ Mrs. Patterson (mother) Ethel

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9.	6.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS
10 NAME OF FATHER John Carter.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Ethel Patterson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed OCT 31 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1921. to Oct 28. 1921.
that I last saw her alive on Oct. 28 1921.
and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:
Dysentery

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home —
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Culture Flexner.
(Signed) Horace G. Stewart, M. D.
10/29. 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pat Cultures Cemetery	Oct 31 1921
20 UNDERTAKER James A. Deans	ADDRESS 1 303 Gilmore

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Flexner type dysentery

6-9-19 H. P. Co.—1000 Blks.

D58196 HEALTH DEPARTMENT—CITY OF BALTIMORE D58196

CERTIFICATE OF DEATH. 1202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S. 5th St., 7th Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Martin

(a) RESIDENCE. No. 125 S. 5th St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip J. Martin

6 DATE OF BIRTH (month, day, and year): Mar - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10 NAME OF FATHER: Wm. Slattery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire.

14 Informant (Address): P. J. Martin 1258 S. 5th St.

15 [illegible] 19 [illegible] Registrar

OCT 31 1921

[illegible] Clerk

CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). (d) For deaths due to external causes, state the accident, injury, or violence which produced death. This information is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 19 27, to Oct 29, 19 27, that I last saw her alive on Oct 28, 19 27, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions a Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. J. Fiddes, M. D.

Oct 29 1927 (Address) 3323 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lafayette Cemetery — DATE OF BURIAL: 11-2-1927

20 UNDERTAKER: J. G. Moran — ADDRESS: 300 E. Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Mikalajunas)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58197

CERTIFICATE OF DEATH.

90 D 58197

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 529 Columbia Ave. ST.: (WARD) 24

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genovia Mikalajunas

(a) RESIDENCE. NO. 529 Columbia Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ignac. Mikalajunas

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	mo 6	[illegible]	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) (37)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Joseph Dalmuna

11 BIRTHPLACE OF FATHER (city or town) Lithuania (State or country)

12 MAIDEN NAME OF MOTHER Petrone Pocius

13 BIRTHPLACE OF MOTHER (city or town) Lithuania (State or country)

14 Informant: Clemens Sukauskas (Address) 516 S. Paca St.

15 Filed 10/31 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/11, 1921, to 10/30/21, 19..., that I last saw h[illegible] alive on 10/29/21, 19..., and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Uremia Prof

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Resident

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? [illegible]

(Signed) F. D. Winnifes M. D.

10/30, 1921 (Address) 130 N. Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 2 1921
20 UNDERTAKER	ADDRESS
Sun Undertaking Co.	425 S. Bond St.

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositar, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritanitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute uremia due to chronic bronchitis which was not tuberculous.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58198 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58198

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1115 Edmondson Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wheeler

(a) RESIDENCE. No. 1115 Edmondson Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Augustus M. Wheeler

6 DATE OF BIRTH (month, day, and year) June 28-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	72	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frederick Lentzen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Emma Fassell
(Address) 1115 Edmondson ave

15 OCT 31 1921 [redacted] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Oct 30, 1921, that I last saw h er alive on Oct 30, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 3 yrs. mos. dr.

CONTRIBUTORY (Secondary) Acute Intestinal Indigestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Murray, M. D.

Oct 31 1921 (Address) 1221 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hamstead Cemetery Md	Nov 2 1921
20 UNDERTAKER	ADDRESS 1946 W. Northern
Harry W. Ehlen	

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58199

CERTIFICATE OF DEATH.

REGISTERED NO. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William French

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed 19 Registrar

Robert P. Harrison, Burial Permit Clerk

OCT 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 19 21

17 I HEREBY CERTIFY, That I attended deceased from October 27, 19 21 to October 27, 19 21, that I last saw h im alive on October 27, 19 21, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mesenteric Thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? Yes Date of 10-27-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

10/28/21 (Address) New City Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health,

ADDRESS OCT 31 1921

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 58200 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58200

CERTIFICATE OF DEATH.

151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 N Washington St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Scheuerman

(Residence in Baltimore: No. 1634 N Washington St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	

6-DATE OF BIRTH, Oct (Month) 30 (Day), 1921 (Year)

7-AGE, X yrs. X mos. X ds. If LESS than 1 day, 1 hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X X
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William J Scheuerman

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Clint Weber

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ..... 191... Robert P. Harrison,
Registrar.

OCT 31 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from OCT 30 1921 191... to OCT 30 1921 191..., that I saw her alive on OCT 30 1921 191..., and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (5 months)
birth twin one

(Duration) X yrs. X mos. X ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) D. H. Duke M. D.

OCT 30, 1921. (Address) 1020 E. NORTH AVE.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	..., 191...
20-UNDERTAKER	ADDRESS

Commissioner of Health.

OCT 31 1921

important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 58201 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58201

151

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West End Maternity

CITY OF BALTIMORE: (No. 112 N. Calhoun ST., 19 WARD)

2-FULL NAME Baby Stauffer

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29—21

7 AGE — Years — Months — Days — If LESS than 1 day, 6 hrs 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Warren Stauffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kansas City Mo.

12 MAIDEN NAME OF MOTHER Josie Berkenshire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Maryland

14 Informant .....
(Address) .....

15 Oct 31 1921, 19 Robert F. Herrison, (86[illegible])
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 29 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1921, to Oct 29, 1921, that I last saw living on Oct 29, 1921, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Prematurs birth by Caesarian section from Eclampsia mother.

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation on mother

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Ernest Cornell Muse M.D.

, 19 (Address) 183 West Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS OCT 31 1921

Commissioner Health,
Per Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. TAKE attention to the following instructions on back of certificate.
TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58202

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2611 Francis (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank B Goodman

(a) RESIDENCE. No. 2611 Francis St., Ward,
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly M Goodman

6 DATE OF BIRTH (month, day, and year) Oct 25 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	36	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 178

(b) General nature of industry, business, or establishment in which employed (or employer) United Railways

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co Maryland

PARENTS

10 NAME OF FATHER James Goodman

11 BIRTHPLACE OF FATHER (city or town) Kent Island (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret A Hadaway

13 BIRTHPLACE OF MOTHER (city or town) Kent Co (State or country) Maryland

14 Informant Mrs Lilly M Goodman (Address) 2611 Francis St

15 Filed OCT 31 1921, 19 J. H. Wehr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to Oct 29, 1921, that I last saw him alive on Oct 28, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Laboratory

(Signed) Emil F. Mayer, M. D.

10/31 1921 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 1 1921
20 UNDERTAKER	ADDRESS
John F Denny	715 Eutaw

CAUSE OF DEATH in plain terms, so that a stranger may understand. See instructions on back of certificates.
TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 D 58203

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjorie Hardy

(a) RESIDENCE. NO. 487 Frederick St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 [illegible] 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Maggie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed OCT 31 1921 18 Jos Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1921. to Oct. 30, 1921.

that I last saw her alive on Oct. 18, 1921.

and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

10/30, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch

DATE OF BURIAL Oct 31 1921

20 UNDERTAKER John F. Denny

ADDRESS 715 Lights

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58204

CERTIFICATE OF DEATH

8-09 D 58204

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.) 1706 Bell Pl. ST. (WARD) 24

2-FULL NAME Florence Gyselman

(a) RESIDENCE. NO. 1706 Bell Pl. ST. 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 2/12/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. Gyselman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Lady Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Geo Gyselman (Address) 1706 Bell Pl.

15 Filed OCT 31 1921 H E Kelm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct ....., 19..., to Oct 31, 1921, that I last saw h-- alive on Oct 30, 1921, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Pertusis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Strutt M. D.

10/31/1921 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 11-1 1921

20 UNDERTAKER Jos. Ludwig Sons — ADDRESS 13 Eighty

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION on back of certificates. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D 58205

D 58205

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2529 Hollins ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William August Boss.

(a) RESIDENCE NO. 2529 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? 28 yrs. 8 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth F Boss

6 DATE OF BIRTH (month, day, and year) Feb 28 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	8	2	

086

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Bell boy.

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel.

(c) Name of employer Emerson Hotel. Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER August Boss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Elizabeth Helmers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Elizabeth F. Boss

(Address) 2529 W. Hollins St

OCT 31 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30 1921

17 I HEREBY CERTIFY, That I attended deceased from October 29 1921, to October 30, 1921.

that I last saw him alive on October 30, 1921.

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Exam.

(Signed) William Mitchell, M. D.

October 30 1921 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 2 1921

20 UNDERTAKER W. M. Calder & Nathan ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Part statement on back of certificates. See instructions on back. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 58206 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58206

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Harford ave ST. 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Burns

(a) RESIDENCE NO. 925 Harford ave ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin E. Burns

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Saml Farr.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant John W. S. Butters

(Address) 925 Harford ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1921, to Oct 31, 1921, that I last saw her alive on Oct 30, 1921 and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 925 Harford Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McFerran M. D.

10/31. 1921 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	Nov. 2, 1921
20 UNDERTAKER Wm Cook	ADDRESS 502 E. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58207

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Prot Infirmary St.: Division St. WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Nelson Thomas

(a) RESIDENCE. No. 1710 N. Calvert ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr James Thomas

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	10	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm D Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Chandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant T. Rowland Thomas

(Address) 1118 N. Calvert St

15 Filed OCT 31 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1921, to Oct. 30, 1921, that I last saw h... alive on Oct. 30, 1921, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Oct. 25, 1921

Was there an autopsy? No.

What test confirmed diagnosis? X Ray

(Signed) George E. W. Haldy M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

All Faith St Marys Cy Nov 1 1921

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 N. Fayette

IMPORTANT. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

(Dorney)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58208

CERTIFICATE OF DEATH.

28

D 58208

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Brookfield Ave St., 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm M Dorney

(Residence in Baltimore: No. 2116 Brookfield Ave St.: Same, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 30, 1849. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
72 yrs. 1 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): (

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, W. Dorney

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Dove

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Dorney

(Address) 2116 Brookfield Ave

15-

Filed 1921 Robert P. Harrison,

Registrar.

T 31 1921 Burial Permit Clerk

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1919, to Sept 31 19[illegible], that I saw h[illegible] alive on Oct 31 19[illegible], and that death occurred, on the date stated above, at 12[illegible] m.

The CAUSE OF DEATH* was as follows: Tuberculosis of Lungs

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Edwards M. D.

Oct 31 1921 (Address) 700 N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Nov 2, 1921.
20-UNDERTAKER	ADDRESS
J D Mitchell	1201 W Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 150 D 58209

D 58209

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 W. Saratoga ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia Clarke

(a) RESIDENCE. NO. 1801 W Saratoga ST., WARD. Sykesville Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7 months	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sykesville Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence R Clarke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sykesville Md.

12 MAIDEN NAME OF MOTHER Norma Fleming

13 BIRTHPLACE OF MOTHER (city or town) Mt Airie
(State or country) Carroll Co Md

14 Informant Clarence R Clarke
(Address) Sykesville Md.

15 Filed 19 Robert P. Harrison, Registrar

31 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1921

17

I HEREBY CERTIFY, That I attended deceased from June, 1921, to Oct 31, 1921,

that I last saw h.. alive on Oct 31st, 1921,

and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Congenital heart disease

life (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Physical

(Signed) Charles L. Summers, M. D.

, 19 (Address) 11 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville Md	Nov. 2 1921
20 UNDERTAKER	ADDRESS
Jno. R. Weer	Sykesville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58210 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 170 D 58210

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813 Windsor Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Riggin

(a) RESIDENCE. No. 2813 Windsor Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Clinton

6 DATE OF BIRTH (month, day, and year) ? ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Yard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Riggin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margaret Riggin
(Address) 2813 Windsor Ave

15 JAN 31 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1921, to Oct 28 1921, that I last saw h[illegible] alive on Oct 28 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of No

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. Bentley Gr. M. D.

19 (Address) 1340 Cleveland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	1/3/21 19
20 UNDERTAKER J J Fahey & Sons	ADDRESS 1218 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates.
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58211

CERTIFICATE OF DEATH.

D 58211

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1342 N Fremont Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L. Kelly Jr.

(a) RESIDENCE. NO. 1342 N Fremont Ave ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 22/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robt L. Kelly Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Grace Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Robt L Kelly (Address) 1342 N Fremont Ave

15 NOV 1 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1921, to Oct 31, 1921, that I last saw him alive on Oct 30, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

OVER

Broncho-pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

10/31. 1921 (Address) 2005 Hillsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 1 1921

20 UNDERTAKER Daniel Easton ADDRESS 916 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATIONS on back of certificates.

TION is very important. See instructions on

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58212 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58212

CERTIFICATE OF DEATH. 185

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp ST., 18 WARD)

2-FULL NAME Wilbur Swartz

(a) RESIDENCE. No. N & C Hosp ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. —
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4 ?	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER John Swartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Betterton Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Miss George A. Sutton
(Address) N & C Hospital

15 FILED NOV 1 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30/1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3d, 1921, to Oct 30th, 1921, that I last saw h in alive on Oct 30th, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Intoxication (duration) — yrs. — mos. 27 ds.

CONTRIBUTORY (Secondary) Acidosis (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm J Faugler M. D.

, 19 (Address) 700 E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 1 1921

20 UNDERTAKER George J Smith ADDRESS 1000 25 Druid Hill Ave

CAUSE OF DEATH must be properly certified, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58213

CERTIFICATE OF DEATH.

64 D 58213

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 417 S. Mon to 2 11 St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Morgan

(Residence in Baltimore: No. 417 N. Monument St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 20, 1852
(Month) (Day) (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook 071
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Stonebraker

(Address) 417 N. Mon St.

15- Filed NOV 1 - 1921 ROBERT J. BRAUTEN Registrar. Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 30th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1921, to Oct 30th, 1921, that I saw h[illegible] alive on Oct 29th 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis

Immediate (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) A. Fen Ellis M. D.

11/3, 1921 (Address) 42 Mont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pt. Cemetery Lane — DATE OF BURIAL, Nov 1st, 1921

20-UNDERTAKER Sam'l S. Hemsley ADDRESS 1528 Riddle St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58214 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

151 D 58214

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 E. Fayette ST.; 6 WARD)

2-FULL NAME Annie Genco

(a) RESIDENCE. No. 2221 E. Fayette ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 Hours Ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31/21

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or ..... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Casper Genco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Marie Testudeno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Casper Genco

(Address) 2221 E Fayette

15 Filed NOV 1 - 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1921, to Oct. 31, 1921, that I last saw her alive on Oct. 31, 1921, and that death occurred, on the date stated above, at 2 P.t. m.

The CAUSE OF DEATH* was as follows:

6 months miscarriage

(duration) ..... yrs. ..... mos. 3/5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pesaj no, M. D.

11. 1, 21. (Address) 3 on Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Nov 1st 1921
20 UNDERTAKER Philip Herrig	ADDRESS 2016 Aliceus

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. See back of certificates.
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58215

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 58215

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 n. Dallas ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruffus McClure

(a) RESIDENCE. No. 807 n. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer-Lab

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Live in Balt- 13 years Born in S. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant Mrs Ella C. McClain
(Address) 1769 Carlisle Place

15 NOV 1 - 19[illegible] Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1921, to Oct 30, 1921, that I last saw h[illegible] alive on Oct 29, 1921, and that death occurred, on the date stated above, at 8 20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓ ✓

(Signed) J. Edward Fisher, M. D.

10-30-21 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shaw's-Chases Station	Nov 1 1921
20 UNDERTAKER Balt-Co	ADDRESS 1725-
Mrs Robert-A Elliott	Ashland Ave

D 58216

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D 58216

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Hanover St. 23 WARD)

2-FULL NAME Blanche A. MacKenthun

(Residence in Baltimore: No. life 1205 Hanover St.; ..... yrs. ..... mos. ..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: April (Month) 23 (Day), 1881 (Year)

7-AGE: 40 yrs. 6 mos. 8 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Patrick Conway

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Blanch A. Conway

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles MacKenthun

(Address) 1205 Hanover St

15- Filed NOV 1 - 1921, 191.....

[illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to, Oct. 30 1921, that I saw her alive on Oct. 30 1921, and that death occurred, on the date stated above, at 1.26 a.m.

The CAUSE OF DEATH* was as follows:

Passive Congestion of Liver + C

0780

4078

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Congestion of stomach & Kidneys 0780 4078 (Duration) ..... yrs. ..... mos. 7 ds.

(Signed), C. Haun M. D.

Oct. 31, 1921 [Address] 1215 Hanover St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Western Cem.

DATE OF BURIAL: Nov. 3 1921

20-UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Eight St.

NOTE: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58217

CERTIFICATE OF DEATH.

91 D 58217

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Farr

(a) RESIDENCE. No. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed NOV 1 - 1921 . 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 6, 19 15, to October 29, 19 21

that I last saw h[illegible] alive on October 29, 19 21

and that death occurred, on the date stated above, at 10:10 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

10/31/21 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/1/21

20 UNDERTAKER Geo. G. Finley Sutton & Sayelle ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58218 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Hilt

(a) RESIDENCE. NO..... ST., ... WARD. Louisville Ky.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kentucky
(State or country)

PARENTS

10 NAME OF FATHER Alexander Hilt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Alice Appleton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Kentucky.

14 Informant W. J. Swezey Warden.
(Address)

15 NOV 1 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26-1921

17 I HEREBY CERTIFY, That I attended deceased from September-1, 1921, to October 26, 1921, that I last saw him alive on October 26, 1921, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Milliary Tuberculosis

(duration) yrs. 1 mos. 26 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Sputum

(Signed) William H. Schwartz, M. D.

Oct 26 1921 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louisville Ky NOV

DATE OF BURIAL: 1 - 1921

20 UNDERTAKER: Brown & Cleland

ADDRESS: 914 N Schroeder

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58219

CERTIFICATE OF DEATH.

109 D 58219

REGISTERED NO. C 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 W. Baltimore ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Elleanora Roth

(Residence in Baltimore: No. 1926 W. Baltimore St. St.: 60 yrs., 8 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 10 (Month) (Day), 186 (Year)

7-AGE, 60 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Joseph Hackett

11-BIRTHPLACE OF FATHER (State or Country) Balto - md

12-MAIDEN NAME OF MOTHER W. Buchtmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. G. Roth

(Address) 1926 W Balto St

15- Filed NOV 1 - 1921, 191... ROBERT A. FOSTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1921, to Oct. 28, 1921, that I saw her alive on Oct. 27, 1921, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Neurasthenia Gastrica

(Duration) ....yrs. ....mos. 10 ds.

(Signed) E. A. Dickey M. D.

Oct. 29, 1921. (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Nov 2d, 191...

20-UNDERTAKER H B Hepfinger

ADDRESS 2236 Eutaw av

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58220

CERTIFICATE OF DEATH.

X H 1 D 58220

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Beth H. Thompson.

(a) RESIDENCE. NO. Alderson West Va. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 72 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alderson W. Va

PARENTS

10 NAME OF FATHER: Robert E Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentland

12 MAIDEN NAME OF MOTHER: Eliza H. Rumaide

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Va.

14 Informant: JOHNS HOPKINS HOSPITAL. Record
(Address)

15 Filed NOV 1 - 1921 Registrar's No. 1 [illegible]
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 - , 1921 , to Oct 31 - , 1921 .

that I last saw her alive on Oct 31 - , 1921 ,

and that death occurred, on the date stated above, at 5:55 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 25, 21

Was there an autopsy? Positive

What test confirmed diagnosis?

(Signed) Leo Brady, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alderson W. Va.	Nov. 1 1921
20 UNDERTAKER	ADDRESS
William G. Schaeffer	1816 Monument

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58221 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58221

61-10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4204 Edmondson Ave WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J Sayer

(a) RESIDENCE No. 4204 Edmondson AVE. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 2 1916

7 AGE: Years 5; Months; Days 29; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Ambrose G Sayer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Estelle E Bahr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Ambrose G Sayer

(Address): 4204 Edmondson Ave

15 Filed NOV 1 - 1921 NOTICE RECEIVED Burial Permit Issued

Burger 1405 Edmondson Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1921, to Nov 1, 1921, that I last saw him alive on Oct 31, 1921, and that death occurred, on the date stated above, at 1 45 m.

The CAUSE OF DEATH was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) 4 hours ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) W H Byers M. D.

, 19 (Address) 1405 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 2 1921

20 UNDERTAKER: W H Cook — ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Epidemic form.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58222

CERTIFICATE OF DEATH.

96 D 58222

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2314 Eden St ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Baptist

(a) RESIDENCE. No. 2314 Eden St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Manager.

6 DATE OF BIRTH (month, day, and year): Unknown 1870

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer): Working mill Plumber

(c) Name of employer: Millerhouse.

9 BIRTHPLACE (city or town) (State or country): Richmond Va.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Robert Lee Lord (Address) 649 E Monument St.

15 NOV 1 - 1921 BOARD OF HEALTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1921, to Oct 29, 1921, that I last saw h alive on Oct 29, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Severe Cold.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At work.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Medicus, M. D.

, 19 (Address) 1308 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion cemetery	Nov. 1st 1921
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Pierce St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58223 CERTIFICATE OF DEATH. 151 D 58223

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Freeland.

(a) RESIDENCE NO. 373 Precotman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 23

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — OOO

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Harvey Freeland

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie Ellings

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Maryland

14 Informant Johns Hopkins Hospital, Baltimore

(Address)

15 Filed NOV 1 - 1921, 19 ROBERT J. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1921, to Oct. 25, 1921, that I last saw him alive on Oct. 25-5, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	OCT 31 1921
20 UNDERTAKER	ADDRESS

Commissioner Health,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58224 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58224

CERTIFICATE OF DEATH.

172

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Carroll ST., 21 WARD)

2-FULL NAME William Washington

(a) RESIDENCE NO. 1137 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Sept 29 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Rev Geo F Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah R Washington (Address) 1137 Carroll

15 Filed NOV 1 - 1921 ROBERT P. LAMOTTE REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1921, to Oct 30, 1921, that I last saw h[illegible] alive on Oct 30, 1921, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Fracture Hip (Shock)

(duration) yrs. ... mos 24 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? yes Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R Tilley Stoag, M. D.

(Address) 726 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 2 1921

20 UNDERTAKER	ADDRESS
Lowe Cook	502 E Hartford

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58225

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Park Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas R. Brown

(a) RESIDENCE. NO. 1213 Park Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced (or) WIFE of Amanda Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	70	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER T. Thos Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emily (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edward Kerr

(Address) 941 Park ave.

NOV 1 - 1921

[illegible] Registrar

[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/29/21 19 21

17 I HEREBY CERTIFY, That I attended deceased from 27/10/, 1921, to 29/10/, 1921.

that I last saw him alive on 4/11/, 1921.

and that death occurred, on the date stated above, at 6-30 p m.

The CAUSE OF DEATH* was as follows:

(a) Pernicious anemia, debility, etc.

Several months

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Possibly Pylorus Cancer

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Arrayfield Boyle, M. D.

31/10/1924 (Address) 4214 Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery Balto	19 21
20 UNDERTAKER	ADDRESS
John H Todd	142 Hill

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58226

CERTIFICATE OF DEATH.

D 58226

91

REGISTERED NO.....

1-PLACE OF DEATH Municipal Hospital

CITY OF BALTIMORE: (No. ..... ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Lucky

(a) RESIDENCE. NO. 236 S Madeira ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 25 yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Whit	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records

(Address)

NOV 1 - 1921

[illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-1921

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1921, to 10-30, 1921 that I last saw h[illegible] alive on 10-30, 1921 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Clyde McNeil, M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Nov 2 1921

20 UNDERTAKER John A Weber

ADDRESS 1803 Bank

TION is very important. See instructions on back of certificates.

Gosk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58227

CERTIFICATE OF DEATH.

151 D 58227

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 835 E Baltimore St ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Gosk

(Residence in Baltimore: No. 835 E Baltimore St St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Nov 1, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 16 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country). 835 E Baltimore St Baltimore Md

PARENTS.

10-NAME OF FATHER, John Gosk

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Anna Bralanowska

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Gosk

(Address) 835 E Baltimore St

15- Filed NOV 1 - 1921 19... [illegible] Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Wm Mosby M. D.
(Coroner.)

Nov 1, 1921 (Address) Both Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov. 1, 1921

20-UNDERTAKER John A Weber — ADDRESS 1803 Bank

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58228

CERTIFICATE OF DEATH.

79 D 58228

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Eastern av ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Goltowska

(a) RESIDENCE NO. 1736 Eastern av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislaus Goltowski

6 DATE OF BIRTH (month, day, and year) Oct 28-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Zerbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Goltowski (Address) 1731 Eastern ave

15 NOV 1 - 1921 ROBERT I KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/28, 1921, to 10/30, 1921, that I last saw h[illegible] alive on 10/30, 1921, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation &
acute cardiac dilatation

(duration) yrs. 2 mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema & Cirrhosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

10/31, 1921 (Address) 162 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] St Stanislaus

DATE OF BURIAL Nov 3 1921

UNDERTAKER John M Weber

ADDRESS 1803 Bank st.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58229

CERTIFICATE OF DEATH.

28 D 58229

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospit ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rush

(a) RESIDENCE. No. 506 Cross st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unkn own yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katie Rush

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Rush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Jane Wall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) M.T.H.

NOV 1 - 1921

BOREN A KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1921, to Oct. 30, 1921, that I last saw him alive on Oct. 29, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L Delaglucell M. D.

10-30-21 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov. 2 1921
20 UNDERTAKER	ADDRESS
A. L. Bloom'd Son	1811 W. Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99 D 58230

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Raymond and Mary Rich St. 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frances E Vey

(Residence in Baltimore: No. 1111 Eastend.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1867. (Year)

7-AGE,	If LESS than 1 day,
54 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ingold Watchmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 06 V

9-BIRTHPLACE, (State or Country). England.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Father England

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- NOV 1 - 1921 [redacted] KRAUTH

Filed ..... 191.. [redacted] Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatism
Valv dis heart
Sudden (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner.)
Oct 31, 1921 (Address) 659 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park cemetery	Nov 1, 1921
20-UNDERTAKER	**ADDRESS**
James F Quan & Son	1000 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58231

CERTIFICATE OF DEATH.

64 D 58231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Forest Road, Roland Park ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. McFee

(a) RESIDENCE. No. 515 Forest Road, Roland Park ST. WARD.

(Usual place of abode) About

Length of residence in city or town where death occurred 69 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry B. McFee

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 69	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Wall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary B. Nunan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant J. Edgar Gans
(Address) Govans, Md.

NOV 1 - 1921 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1919, to Oct. 30, 1921, that I last saw h[illegible] alive on Oct. 30 1921, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Interstitial Nephritis with Arteriosclerosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. T. Mears, M. D.

11/1, 1921 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/2 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 58232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 N. Chester St., 6 Ward)

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tobie Lerner

(a) RESIDENCE No. 23 N. Chester St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mendal Lerner

6 DATE OF BIRTH (month, day, and year) —— 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Kornman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) I. Lewis 1411 E. Balto. St.

15 Robert T. Harrison, Burial Permit Clerk. Registrar

1-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1919, to Nov 1, 1921.

that I last saw h alive on Oct 31. 1921,

and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis, Emphysema

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

Nov 1, 1921 (Address) 360 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Wilson Rosedale — DATE OF BURIAL 11/12 1921

20 UNDERTAKER Jack Lewis, ADDRESS 1411 E. Balto. St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58233 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58233

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Fonthill Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy a Johnson

(a) RESIDENCE. No. 410 Fonthill Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9/11/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

800

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry J Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Stella Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Estelle Johnson (Address) 410 Fonthill Ave

15 Filed NOV 1 - 1921 H Welsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1/1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1921, to Oct 31, 1921, that I last saw h— live on Oct 31, 1921, and that death occurred, on the date stated above, at 330 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hubert Davis, M. D.

, 19 (Address) 1109 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park Nov 2 1921

20 UNDERTAKER C. W. Dill ADDRESS 3109 Frederick Ave

TION is very important. See instructions on back of certificates.

D 58234

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 58234

1 PLACE OF DEATH

(REGISTERED No. C 40)

CITY OF BALTIMORE (No. 1319 N Calvert ST.: 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christopher Columbus Shriver

(Residence in Baltimore: No. 1319 N Calvert St.: 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: MALE

4 COLOR OR RACE: WHITE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: MARCH 31st, 1840 (Month) (Day) (Year)

7 AGE: 81 yrs. 7 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: BANK OFFICIAL
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9 BIRTHPLACE (State or country): UNION MILLS, CARROLL CO MD

PARENTS

10 NAME OF FATHER: WILLIAM SHRIVER

11 BIRTHPLACE OF FATHER (State or country): UNION MILLS, MD

12 MAIDEN NAME OF MOTHER: MARY OWINGS

13 BIRTHPLACE OF MOTHER (State or country): CARROLL COUNTY, MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) MRS CORA P SHRIVER

(Address) 1319 N Calvert St

15 Robert P. Harrison, ..., 191
Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 30th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7th, 1921, to Oct 30th 1921, that I saw him alive on October 29th, 1921, and that death occurred, on the date stated above, at 9 A m.
The CAUSE OF DEATH* was as follows:

CANCER OF STOMACH

first consulted Aug 7th 1921 (Duration) yrs. 2 mos. 23 ds

Contributory (SECONDARY) ... (Duration) yrs. mos. ds.

(Signed) Thomas L. Sheppard M. D.

Nov 1st, 1921 (Address) 705 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: 11-2-1921

20 UNDERTAKER: Henry W Jenkins & Sons Co — ADDRESS: McCulloh & Orchard

1-1921

X B-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58235

CERTIFICATE OF DEATH.

81

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1420 North Bond Street. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dempsey

(a) RESIDENCE. NO. 1420 N. Bond Street. ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John. Dempsey

6 DATE OF BIRTH (month, day, and year) Mar. 25- 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mamie Dempsey
(Address) 1420 N. Bond St.

15 Filed 10 Robert F. Harrison, Registrar
Burial Permit Clerk.

1-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Oct 30, 1921, that I last saw h.. alive on Oct 30, 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Senile Gangreen of both Legs

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1420 Bond St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

10/31 1921 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Nov 3 1921

20 UNDERTAKER Chas. D. Evans & Son

ADDRESS 118 N. McKenzie Ave

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Read statement of U. S. P. H. S. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58236

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 425 N Fremont ST.; 17 WARD)

2-FULL NAME Samuel S. Tynes

(a) RESIDENCE. No. 425 N Fremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mary Tynes

6 DATE OF BIRTH (month, day, and year) July 15, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Plant

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Stevenson Tynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) B. W. I.

12 MAIDEN NAME OF MOTHER Ella Brayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Tynes
(Address) 425 N Fremont

15 Filed ——, 19—

Registrar

1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30/1921

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1921, to Oct 30, 1921, that I last saw him alive on Oct. 30, 1921, and that death occurred, on the date stated above, at 8.40 p m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Reg.

(Signed) W. F. Mobilio, M. D.

11/1/1921 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 2 '21
20 UNDERTAKER David Easton	ADDRESS 916 Penna ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58237

D 58237

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2250 Brookfield Av ST.) (13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Meyer

(a) RESIDENCE. NO. 2250 Brookfield Av ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Meyer

6 DATE OF BIRTH (month, day, and year): April 17/1857

7 AGE — Years: 64 — Months: 6 — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mnfg of

(b) General nature of Industry, business, or establishment in which employed (or employer): Clothing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: S Rosenthal

(Address): 502 Newington

15 Filed ..... 19 ..... ROBERT P. HARRISON, Registrar

Burial Permit Clerk

1 — 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31st 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1921 to Oct 31 1921

that I last saw h[illegible] alive on Oct 30 1921

and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Lung

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) S. Wolman M. D.

, 19 (Address) 2444 E Int Av Cl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai — DATE OF BURIAL: Nov. 2nd 1921

20 UNDERTAKER: Harris Goodman — ADDRESS: 1180 W Baltimore

INSTRUCTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58238

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Linden ave St.: 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME, Katherine J. Freeny

(a) RESIDENCE. No. 1305 Linden Ave St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Oscar Freeny

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Otis Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Margaret C. Bier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edith Wells Freeny

(Address) 1305 Linden Ave

15 Filed Robert P. Harrison, Registrar

1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17

I HEREBY CERTIFY, That I attended deceased from 21 Oct. 1921. to 30 Oct. 1921.

that I last saw her alive on 30 Oct. 1921.

and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Sclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Horace W. Byers, M. D.

, 19 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 2 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58239 HEALTH DEPARTMENT--CITY OF BALTIMORE D 58239

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 719 E. 21st 9 St.; 9th WARD)

REGISTERED NO. C 151

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Richard & Anna Reppert

(Residence in Baltimore: No. 719 E. 21st St. St.: yrs. 15 mins mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: October 27th, 1921 (Month) (Day) (Year)

7 AGE: yrs. mos. ds.

If LESS than 1 day hrs. or 15 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Balto. Md. U.S.A.

PARENTS

10 NAME OF FATHER: Richard Franklin Peckard

11 BIRTHPLACE OF FATHER (State or country): U.S.A.

12 MAIDEN NAME OF MOTHER: Anna Gertrude Beacham

13 BIRTHPLACE OF MOTHER (State or country): U.S.A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard F. Reppert

(Address) 719 E 21st Street

15 Filed NOV 1 1921, 191

Robert P. Harrison, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 27th, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 27th, 1921, to 191, that I saw h alive on October 27, 1921, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

3½ Mo Abortion 15 minute
(Duration) yrs. mos. ds

Contributory (SECONDARY) Hemorrhage
(Duration) yrs. mos. ds.

(Signed) Howard A. Kelly M. D.

(Address) 530 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: HOPKINS HOSPITAL DATE OF BURIAL .191

20 UNDERTAKER ADDRESS NOV 1 - 1921

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58240

D 58240

66

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Estend St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Granger

(a) RESIDENCE. No 1223 Estend n St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 9 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single, Married, Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward A. Granger

6 DATE OF BIRTH (month, day, and year): Jan 1 1874

7 AGE — Years: 47 — Months: 9 — Days: 29 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 637

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Edlitk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Rukland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: Edward A. Granger
(Address): 1223 Estend n St

15 Filed: Robert P. Harrison, Registrar

1 — 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1921, to Oct 30, 1921, that I last saw h[illegible] alive on ....., 19..., and that death occurred, on the date stated above, at 9 1/2 m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

OVER

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis & Hemoplegia, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hayward Dr Stein, M. D.

, 19 (Address) 1227 Columbus

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 2 1921

20 UNDERTAKER: Jos Joesdens Son ADDRESS 2173 Pac

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.
No nephritis Hemiplegia
due to high blood
pressure.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58241

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58241

X 50-09 r

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Gen. Hospital ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eliza J. Smith

(a) RESIDENCE. NO. 642 W F Franklin ST., WARD. Cherry Tree Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvin Smith - deceased

6 DATE OF BIRTH (month, day, and year) Feb 3. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Chambersville, Ind Co. Pennsylvania

10 NAME OF FATHER Jeremiah Peterman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind Co. Pennsylvania.

12 MAIDEN NAME OF MOTHER Mary Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind. Co. Pennsylvania.

14 Informant Janet E. Neglett

(Address) South Balto. Gen. Hospital

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1921

17

I HEREBY CERTIFY, That I attended deceased from October 30, 1921, to November 1, 1921, that I last saw her alive on November 1, 1921, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH was as follows:

Diabetis Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Pokorny, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 4 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58242

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2928 (Street) Violet Eliz Keenan (Ward) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 2928 Linwood ave

(a) RESIDENCE. No. 2928 (Usual place of abode) Linwood ave WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas J Keenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto —

12 MAIDEN NAME OF MOTHER Violet E Hearn

13 BIRTHPLACE OF MOTHER (city or town) Salisbury (State or country) Md.

14 Informant (Address) Ethas J Keenan 2928 Linwood Ave

15 Filed Nov 10 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 19 21

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1921, to Nov 1, 1921, that I last saw her alive on Oct 31, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pertussis — Bronchitis —

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr, M. D.

11/1, 1921 (Address) 2800 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 2 1921

20 UNDERTAKER	ADDRESS
H B Wippert	2236 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58243

HEALTH DEPARTMENT—CITY OF BALTIMORE

1004
175-D 58243

CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(PLACE OF DEATH

CITY OF BALTIMORE (No.) St Josph. Hospital ST. 9 WARD)

2-FULL NAME Barbara Eis

(Residence in Baltimore: No. 1805 Hanover St.; 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. (Month) 1 (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER Ant. Kroon

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ant. Kroon

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Eis

(Address) 1805 Hanover St

15-

Filed Nov 1 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

X Pneumonia, lobar
by Illness cor

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Klein Snider M. D.
(Coroner.)

Nov 1, 1921 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov 2, 1921

20-UNDERTAKER Frank Boettler — ADDRESS 1916 Eastlander

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Julia Patterson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58244

D 58244

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 815 Warner ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Patterson

(a) RESIDENCE. NO. 815 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 801

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James Williams (Address) 815 Warner St

15 NOV 2 - 1921 ROBERT A. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to Oct 29, 1921, that I last saw h alive on Oct 28, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemrhge

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Ca Pharynx

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 815 Warner St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Flowers, M. D.

, 19 (Address) 714 S Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Nov 2 1921

20 UNDERTAKER: John H. Trader — ADDRESS 142 Utica St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58245

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D 58245

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 W. Lee ST. W WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R. Gantt

(a) RESIDENCE. No. 629 W. Lee ST., ... WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Fuchs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo W. Gantt
(Address) 629 W Lee St

15 NOV 2 - 1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20th, 1921, to Oct. 30th, 1921, that I last saw her alive on Oct. 30th, 1921, and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Cantwell, M. D.

11/1 1921 (Address) 1400 W. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 2 1921
20 UNDERTAKER John H Toadvine	ADDRESS 172 Uniform St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

Gentile

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58246

CERTIFICATE OF DEATH.

92-078 D 58246

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital St.; No. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicola Gentile

(a) RESIDENCE. No. 403 S. Eden St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER A. Gendile

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER L. Gendile

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Henry Gentile
(Address) 403 S Eden St

15 NOV 2 - 1921 [illegible] KRAUSE
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1921, to 10-31, 1921, that I last saw him alive on 10-31, 1921, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical exam.

(Signed) F. A. Holden M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 4, 1921
20 UNDERTAKER	ADDRESS
Wendell Hoppe & Son	57 N Amity

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58247

CERTIFICATE OF DEATH.

64 D 58247

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 524 N. Fremont Ave (WARD) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E. H. Pherson

(a) RESIDENCE. NO. 524 N. Fremont Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Virginia E. H. Pherson

6 DATE OF BIRTH (month, day, and year) Sept 14 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Zachariah H. Pherson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Fancy A. Knight

(Address) 524 N. Fremont Ave

15 NOV 2 - 1921 ROBERT A. KRAUTER Registrar Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921, to Oct 30, 1921, that I last saw h[illegible] alive on Oct 26, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Manley Strong, M. D.

19 (Address) 729 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Nov 2 1921
20 UNDERTAKER	ADDRESS
Geo. W. Lisle	2 [illegible] Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58248

CERTIFICATE OF DEATH.

54 D 58248

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colgate Creek ST., Park of Canton Roland 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Smith

(a) RESIDENCE NO. Colgate Creek ST., South of 27th St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Sex~~ Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Henry A. Smith

6 DATE OF BIRTH (month, day, and year) Sept 28, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Dannenfelser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Annie Frazier (Address) 1303 E Clinton St

15 NOV 2 - 1921 ROBERT A LEAUTEY Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 13 1921, to October 30 1921, that I last saw h[illegible] alive on October 30 1921, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Caleb R. Athey M. D.

(Address) 100 E Pat[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. DATE OF BURIAL: Nov 2 1921

20 UNDERTAKER: H. Sander & Sons ADDRESS: 1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58249

CERTIFICATE OF DEATH.

D 58249

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1022 Stockton ST.; 16 WARD)

2-FULL NAME Charlotte Horsley

(a) RESIDENCE. No. 1022 Stockton ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred mos. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr Rogers

(Address) 1022 Stockton St

15 NOV 2 1921 BOARD OF HEALTH

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-23-, 1921, to 10-29-, 1921, that I last saw h alive on 10/25-, 1921, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Gastritis

Several Months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Obstinate Constipat

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1022 Stockton

Did an operation precede death? N/A Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Boykin M. D.

, 19 (Address) 1618 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Nov 1 19

20 UNDERTAKER Edward Ruggold

ADDRESS 1463 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

Carl C. Perry.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58250

CERTIFICATE OF DEATH.

5 D 58250

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1225 Maiden St Howard St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl C. Perry.

(Residence in Baltimore: No. 1225 Main St Howard St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Nov 1, 1921
(Month) (Day) (Year)

7-AGE, Nov yrs. Nov mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant 6 Days
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Lenge W. Perry.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary E Hammas.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lenge W. Perry

(Address) 1225 Howard

15- Filed NOV 2 - 1921 191.. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 2 1921, that I saw h[illegible] alive on Nov 1 1921, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth 6 Days

(Duration) Nov yrs. Nov mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) Raymond S Johnson M. D.

Nov 2, 1921 (Address) 1225 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Nov 4th, 1921.

20-UNDERTAKER Knell & Son

ADDRESS 1217 Warren Ave

may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58251 ✓ D 58251

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3428 Ash. St ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriett M. Storton

(Residence in Baltimore: No. 3428 Ash. St ST.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown ....., ... (Month) ..... (Day) ..... (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER John T Watson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Julia Reed

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Watson

(Address) 3428 Ash St

15- Filed NOV 2 - 1921 ROBT. J. KRAUTER Registrar

Burial Permit Required

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15-21, to Oct 31-21, that I saw h Sr alive on Oct 30-21, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

(Ty/Co stat.) Pneumonia

Colon Obst

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Fracture Femur, Closed

Carc. of Rectum (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) B. F. Lerch M. D.

Oct 1, 1921 (Address) 1527 Mount St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Moriah | DATE OF BURIAL, Nov 2, 1921

20-UNDERTAKER A D Marshall | ADDRESS 2530 Pall Mall

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58252

D 58252

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1427 Columbia Ave. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Catherine Collins

(a) RESIDENCE. No. 1427 Columbia Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13" 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel E. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Cora V. Smardon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Daniel E. Collins
(Address) 1427 Columbia Ave.

15 NOV 2 - 1921 ROBERT J. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31" 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29 1921, to Oct. 31, 1921, that I last saw her alive on Oct. 31, 1921, and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Entero - Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Maurice E. Shamm, M. D.

10/31, 1921 (Address) 3300 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov. 2" 1921
20 UNDERTAKER	ADDRESS
Joseph B Cook	1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 123 D 58253

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hosp. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Killmon.

(a) RESIDENCE. NO. Towsonville Va ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr. Claude F. Killmon.

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Accomac Co
(State or country) Virginia

PARENTS

10 NAME OF FATHER Benjamin Wallace

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Bradford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant J. D. Phillips
(Address) Emelfa Va

15 Filed NOV 2 - 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1921, to Oct. 31, 1921, that I last saw him alive on Oct. 31, 1921, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Embolism following nephrotomy 10 days ago for renal calculus.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 21, 1921.

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Robert E. Fricke, M. D.

19 (Address) 1718 Eutaw Place, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parksley Va.	Nov 2 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Fayette Ave.

Electric Point Boggs attach

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Bessel)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58254

CERTIFICATE OF DEATH.

9VD 58254

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Bessel

(Residence in Baltimore: No. 1126 Cleveland Av. St.; 40 yrs., 8 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Divorced

6-DATE OF BIRTH, ... Feb. 7, 1881
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
40 yrs. 8 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Jackson-Contractor

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, George H. Bessel

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Theresa Lang

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Theresa Bessel

(Address)..... 1126 Cleveland St

15-

NOV 2 - 1921 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov. 1, 1921 (Address) 2552 Edmondson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp In the of death.....yrs.....mos. 1 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

1126 Cleveland Av

Former or usual residence 1126 Cleveland Av

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov 3, 1921

20-UNDERTAKER	ADDRESS
Mrs Mrs J W Tenfel & Son	801 N Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form 6-0-19 H. D. C. — 1000 Bks.

D 58255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58255

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 1 ST.: N WARD 117)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Burkheimer.

(a) RESIDENCE. NO. Finchboro. Md. ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1864

7 AGE: Years 57 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Burkheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie Hagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Ellen Kolscher (Sister)
(Address) 807 Light St

15 Filed NOV 2 - 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1921, to Oct. 31, 1921, that I last saw h[illegible] alive on Oct. 31, 1921, and that death occurred, on the date stated above, at 430 P. m.

The CAUSE OF DEATH* was as follows:

Localized Peritonitis upper R. abdomen. Abscess omentum.

(duration) yrs. [illegible] mos. 6 weeks. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Edema Lungs. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 24, 192

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Cyrus D. Horine, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Finchboro Md (Via Auto)	Nov 2 1921
20 UNDERTAKER: John F. Denny	ADDRESS: 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This man was operated Oct. 24, 1921 for abscess in upper right abdomen. Drains were inserted and cause of abscess not determined because patient was so ill that it was necessary to get him off table as quickly as possible. He developed a fecal fistula and died Oct. 31, 1921. Autopsy shows that he had abscess of appendix.

Eugene F. Hoxie M.D.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 V D 58256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S Caroline ST.; 3 WARD)

2-FULL NAME Infant Hassid

(a) RESIDENCE. No. 211 S Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		-	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Julius Hassid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Levin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant J. Levin
(Address) 1411 E. Balto.

15 Filed NOV 2 - 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1921, to Nov 1, 1921, that I last saw h.e alive on Nov 1, 1921, and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows:

Fetal Malformation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Congenital

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Baylis, M. D.

11/2, 1921 (Address) 20 Lexington st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	11-2 1921
20 UNDERTAKER	ADDRESS
Jack Lewis,	1411 E. Balto.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 58257

HEALTH DEPARTMENT—CITY OF BALTIMORE. D 58257

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1322 Rutter ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Robinson

(a) RESIDENCE (Usual place of abode) No. 1322 Rutter ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Mar - 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~28~~	28	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster shucker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Dain Baltimore Co~~ Virginia

PARENTS

10 NAME OF FATHER Thomas Robison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anoplis Md

12 MAIDEN NAME OF MOTHER Margret Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anoplis

14 Informant Alice Robison

(Address) 1322 Rutter st

15 Filed NOV 2 - 1921 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 24th. 1921, to Oct 31, 1921, that I last saw h... alive on Oct 31th, 1921, and that death occurred, on the date stated above, at 1 a - m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical signs

(Signed) A. Paul [illegible] M. D.

, 19 (Address) 1354 N Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 2 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

D 58258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58258

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 Baltimore Ave. St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen Bolte

(Residence in Baltimore: No. 664 W. Redwood st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Don't Know

6-DATE OF BIRTH: Don't Know (Month), 1 (Day) (Year)

7-AGE: About 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Don't Know

PARENTS:

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (State or Country): Don't Know

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or Country): Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) No Information

(Address) [illegible]

15-

NOV 2 - 1921 191.. ROBERT J. KRAUSER Registrar. Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry) thereon and from the evidence obtained by said ~~(Inquest, autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know if any

(Duration) yrs. Don't Know mos. ds.

(Signed) A. K. Gorsuch M. D. (Coroner.)

11-2-, 1921 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Rapids Va

DATE OF BURIAL: 11/3/21 19..

20-UNDERTAKER: W. J. Sulmon & Sons

ADDRESS: Penna Ave

N. B. Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Infant Angelo

D 58259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58259

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1348 E Fort ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant not Named

(a) RESIDENCE. NO. 1348 E Fort Ave ST. WARD 4W

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 6h Months Fetal Days If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Jos Jas Angelo

11 BIRTHPLACE OF FATHER (city or town) Newark N.J. (State or country)

12 MAIDEN NAME OF MOTHER Eliz Leunbach

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Mrs Eliz Angelo (Address) 1348 E Fort Ave. City

15 NOV 2 - 1921 ROBERT J KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11, 1 1921

17 I HEREBY CERTIFY, That I attended deceased from 11, 1, 1921, to 11, 1, 1921, that I last saw h[illegible] alive on 11, 1, 1921, and that death occurred, on the date stated above, at 11.05 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Lived 5 minutes)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L J Sudlington M. D.

, 19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evang. Luth. Cem.	Nov 2 1921
20 UNDERTAKER Lilly + Zeiler	ADDRESS 400 N. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE, 1921 D 58260

CERTIFICATE OF DEATH.

92

D 58260

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Vogt

(a) RESIDENCE. NO. 525 S. 12th ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Sing

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob E. Vogt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ.

12 MAIDEN NAME OF MOTHER Katherine Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ.

14 Informant (Address) Jacob E. Vogt. 525 S. 12th St.

15 FILED NOV 2 - 1921 ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1921, to Oct. 31, 1921, that I last saw h alive on October 31, 1921, and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) Frank C. Marino, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov. 2nd 1921
20 UNDERTAKER Lilly + Zeiler	ADDRESS 4033 Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58261

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2836 O.donnell ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Staab

(a) RESIDENCE. NO. 2836 O.donnell ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Staab.

6 DATE OF BIRTH (month, day, and year) 17 March 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Bilby

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr. Peter Staab
(Address) 2836 O'Donnell St

15 FILED NOV 2 - 1921 BURKE J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1921, to Oct 31, 1921, that I last saw her alive on Oct 30, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. McAvoy, M. D.

11/1/1924 (Address) 836 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 3 1921

20 UNDERTAKER Jos. J. Herr ADDRESS 156 W. Luzerne Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58262

D 58262

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1613 N. Chapel ST.: 8 — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Elliott

(a) RESIDENCE. No. 1613 N. Chapel ST., 8 — WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 5-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Chas. E. Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury, Md.

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City

14 Informant Chas. E. Elliott
(Address) 1613 N. Chapel st.

15 NOV 2 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Octob. 31-1921

17 I HEREBY CERTIFY, That I attended deceased from Octob. 28, 1921, to Octob. 31, 1921, that I last saw him alive on October 31, 1921, and that death occurred, on the date stated above, at 2 25 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

11/1/1921 (Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dalesmeley

DATE OF BURIAL Nov. 2 1921

20 UNDERTAKER Robt J. Turner Inc

ADDRESS 1424 Bway

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 58263

1-PLACE OF DEATH

REGISTERED No. C 79 D 58263

CITY OF BALTIMORE (No. 103 S. Catherine St St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Koczorowski

(Residence in Baltimore: No. 103 S. Catherine St. St.; 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M	W	Single

6-DATE OF BIRTH Sept. (Month) 2 (Day), 1872 (Year)

7-AGE 49 yrs. 1 mos. 29 ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE (State or country) Baltimore, Md

PARENTS

10-NAME OF FATHER Ferdinand Koczorowski

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Caroline Klaus

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A. E. Hausman

(Address) 1957 W. Lanvale

15 NOV 2 - 1921 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov (Month) 1 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1919, to Nov 1 1921 that I saw h[e] alive on Oct 31, 1921, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Acute Dilatation of Stomach (Duration) yrs. mos. ds.

(Signed) Fermadge K. Metzger M. D.

Nov 1, 1921 (Address) 904 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park

DATE OF BURIAL Nov. 4, 1921

20-UNDERTAKER George Eschwab

ADDRESS 2101 Pudk. Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58264 ✓ 64 D 58264

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3915 Forest Park Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry S. Regester

(a) RESIDENCE. No. 3915 Forest Park Ave. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate S. Grove

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg'r. Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joshua Regester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Churchill Md.

12 MAIDEN NAME OF MOTHER Esther Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Mrs. Kate S. Regester
(Address) 3915 Forest Park Ave.

15 Filed NOV 2 - 1921 19 BOARD OF HEALTH Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20 1921, to Oct 31st 1921, that I last saw him alive on Oct 31st 1921, and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia R right side due to Cerebral Hemorrhage

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) unknown

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jefferson Buell M. D.

11/1. 1921 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	11/2/21 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son,	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 58265 — CERTIFICATE OF DEATH — 170 — D 58265

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1404 Cairo St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles H. Johnson

(Residence in Baltimore: No. 1404 Cairo St.: 40 yrs. ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Dec 16, 1866 (Month) (Day) (Year)

7 AGE: 54 yrs. 10 mos. 15 ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O4°

9 BIRTHPLACE (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Wm H. Johnson

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Emily Anderson

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Hopkins

(Address) Morgan St Woodlawn

15 Filed NOV 2 - 1921 ROBERT A KRAUTER (Signature) REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 31, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1921, to Oct 31, 1921, that I saw h— alive on Oct 29, 1921, and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH was as follows:

Nephritis Acute
Intestinal

(Duration) 2 yrs. ... mos. ... ds

Contributory (SECONDARY) Myocarditis

(Duration) ... yrs. 6 mos. ... ds.

(Signed) J. H. Byrne M. D.

Nov 1, 1921 (Address) 1408 EDMONDSON AVE

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 3, 1921

20 UNDERTAKER: Brown & Freeland — ADDRESS: 114 N Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Bks.

JORDAN

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58266
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

120 D 58266
REGISTERED NO.

CITY OF BALTIMORE: (No.) 1231 Hollins ST.: 18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catalina Jordan

(a) RESIDENCE. NO. 1231 Hollins ST., 18 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H. Jordan

6 DATE OF BIRTH (month, day, and year) Dec 8-1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Preston

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Sallie Allen

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Clara Jordan
(Address) 1231 Hollins

15 NOV 2 - 1921 19 ROBERT A KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1921, to Nov 1, 1921, that I last saw h[illegible] alive on Oct 31, 1921, and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Ch. Dr. Hospital

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. W. Smith, M. D.

11/1, 1921 (Address) 130 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Preston Cem	11/4 1921

20 UNDERTAKER [illegible] ADDRESS 1318 Light St.

Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58267

CERTIFICATE OF DEATH

37-091

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No.) (S. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Henry Fleet

(a) RESIDENCE. No. 118 W. 20th St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lotner

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bay View Hospital
(Address) Baltimore, Md.

15 Filed 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

NOV 2 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1920 to Nov. 1. 1921

that I last saw h alive on Nov. 1. 1921

and that death occurred, on the date stated above, at 10 30 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis (Luetic infection)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) H. McCormick M. D.

11/1/21 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park Cem. Prince George Co. Md. 11/3 1921

20 UNDERTAKER — ADDRESS

Samuel Hemsley 578 Baker

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58268

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3148 Cedar av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth J. James

(Residence in Baltimore: No. 3148 Cedar av St.; 74 yrs., 9 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan 19, 1847 (Month) (Day) (Year)

7-AGE, 74 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Borden

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Amelia Griffith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin L. Conner

(Address) 3148 Cedar av

15-

Filed ....., 191.... Registrar.

NOV 2 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1921, to Nov 1 1921, that I saw her alive on Nov 1 1921, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Fracture right hip joint

(Duration) ... yrs. ... mos. 48 ds.,

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Edw. Freudenberger M. D.

Nov. 7, 1921. (Address) 3843 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Nov. 3, 1921

20-UNDERTAKER Cohenouvreth & Son — ADDRESS Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58269 HEALTH DEPARTMENT—CITY OF BALTIMORE Lentz 169 D 58269

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. found at Freeway ST.; 2 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Zentz
(Residence in Baltimore: No. 306 S Chester st St.; 3? yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, November 1, 1867
(Month) (Day) (Year)

7-AGE, 53 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chipper 086
(b) General nature of industry, business, or establishment in which employed (or employer): Baltimore Shipyard Co.

9-BIRTHPLACE, (State or Country), Poland

PARENTS.
10-NAME OF FATHER, Zentz
11-BIRTHPLACE OF FATHER (State or Country), Poland
12-MAIDEN NAME OF MOTHER unknown
13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Martin Zentz
(Address) 306 S Chester St

15-
Robert P. Harrison,
Filed ....., 191.... Registrar.
NOV 2 - 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
accidental Drowning
..... (Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) .....
..... (Duration) ....yrs. ....mos. ....ds.
(Signed) Henry Lee Moylan M. D.
(Coroner.)
Nov 2, 1921 (Address) 1500 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Nov. 3 1921
20-UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

Give full information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 58270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) (Ward) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Casper

(a) RESIDENCE. No. 915 S. Milton Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-16-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Casper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Baltimore

15 Filed Robert P. Harrison, Registrar

2-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-25, 1921, to 11-2, 1921, that I last saw h im alive on 11-2, 1921, and that death occurred, on the date stated above, at 5.20 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture.

(Signed) Edwin Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. DATE OF BURIAL: Nov 5. 1921

20 UNDERTAKER: W. F. Sadowski ADDRESS: 905 S. Ann

CAUSE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58271 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58271

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 Ward ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loraine Gertrude Howard

(Residence in Baltimore: No. 1140 Ward St.; yrs. 8 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Femal	white	single

6-DATE OF BIRTH, Feb. 11th, 1921 (Month) (Day) (Year)

7-AGE, yrs. 8 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. md.

PARENTS.

10-NAME OF FATHER, Raymond a Howard

11-BIRTHPLACE OF FATHER (State or Country) Balto. md.

12-MAIDEN NAME OF MOTHER Gertrude B. Bell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude B. Howard

(Address) 1140 Ward St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

NOV 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 1st, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27th 1921, to Nov. 1st 1921, that I saw h[er] alive on Nov 1st 1921, and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro-enteritis

(Duration) yrs. mos. 5 ds.

(Signed) J. E. Sullivan M. D.

11/1/21, 201... (Address) 634 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel Cem	Nov 3, 1921.
20-UNDERTAKER Chas F Wadsmus	ADDRESS 2039 N. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 58272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58272

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 N Calvert ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary Frances Stolt.

(Residence in Baltimore: No. 2303 N Calvert St.: 8 yrs., 6 mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 13 (Day), 1845 (Year)

7-AGE, 76 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Co. Md

PARENTS.

10-NAME OF FATHER, John Wesley Glanville

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Harriett A Adams

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. G. Coppage

(Address) 2303 N Calvert St

15-

Filed ....., 191....

NOV 2 - 1921

Robert P. Harrison,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 2 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 - 1921, to Nov 2 1921, that I saw her alive on Nov 2 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Paralysis - 3 Strokes
Acute Dilatation of Heart.

(Duration) ... yrs. ... mos. 22 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) ... yrs. ... mos. 22 ds.

(Signed) M. G. Coppage M. D.

Nov 3 1921 (Address) 2303 N Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, H. Allen Fuller — DATE OF BURIAL, Nov 4, 1921

20-UNDERTAKER Contrevella, Queen Anne Lev. Md. — ADDRESS 3517 Springdale Ave.

Remarks

Terminal cerebral hemorrhage

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

D 58273

HEALTH DEPARTMENT—CITY OF BALTIMORE

1801

D 58273

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital St. 7 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin Schuler

(Residence in Baltimore: No. 1019 N Caroline St. St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Sept. 4, 1919
(Month) (Day) (Year)

7-AGE: 2 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: John M. Schuler

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md

12-MAIDEN NAME OF MOTHER: Emila Calendar

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emila Schuler
(Address) 1019 N. Caroline St.

15-

Filed ... Robert. H. Harrison, ... Registrar.

12-1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Poisoning,
Pulled Gas gets open,
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas. Green M. D.
(Coroner)
Nov 2, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Mount Carmel — DATE OF BURIAL: Nov 3, 1921

20-UNDERTAKER: William F. Schaffer — ADDRESS: 1816 Harford Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Infant D'Ignazio

D 58274

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 58274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1104 E. Eager ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Boy

(Residence in Baltimore: No. 1104 E. Eager St.; ....yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 2, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds.
If LESS than 1 day, 3 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Angelo D'Ignazio

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rachella Amato

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angelo D'Ignazio

(Address) 1104 E. Eager St

15- NOV 3 - 1921

Filed....., 191.....

Registrar.

M 7A

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191, to ....., 191, that I saw h alive on ....., 191, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Premature Birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Luigi D. Stefano M. D.

Nov 3, 1921 (Address) 407 N Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Vincent Cemetery — DATE OF BURIAL, Nov 3, 1921

20-UNDERTAKER George F. Ruth — ADDRESS 1735 Hanford Ave.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58275

CERTIFICATE OF DEATH.

104 D 58275

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Jenkins Alley ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Underwood

(Residence in Baltimore: No. 1021 Jenkins Alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Blk.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 5, 1921 (Month) (Day) (Year)

7-AGE, yrs. 6 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore - Md.

PARENTS.

10-NAME OF FATHER, Fred Downing

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Ada Underwood

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Underwood

(Address) 1021 Jenkins Alley

15- Filed NOV 3 - 1921, 191.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 1, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 31 1921, to November 1 1921, that I saw him alive on November 1 1921, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Rhachitis

(Duration) yrs. mos. ds.

(Signed) Butler E. Jefferson M. D.

Nov. 2, 1921 (Address) 213 S York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery. DATE OF BURIAL, Nov. 3, 1921

20-UNDERTAKER James H. Deuel ADDRESS 1323 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58276
D ~~58276~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58276
D ~~58276~~

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1551 Leadis St.: 15 WARD) REGISTERED No. C 150

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Eliz. Toy

(Residence in Baltimore: No. 1551 Leadis St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colored	Single

6-DATE OF BIRTH, October 27, 1921
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none.....
(b) General nature of industry, business, or establishment in which employed (or employer).....000.....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Arthur Toy

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Toy

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Toy

(Address) 1551 Leadis St.

15- Filed NOV 3 - 1921, 191.... NOV 3 - 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration)....yrs....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Oct. 31, 1921 (Address) 2812 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery DATE OF BURIAL, NOV 3 1921

20-UNDERTAKER James A. Dennis ADDRESS 1302 Greenmount

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58277

79-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital 5 REGISTERED NO. C D 58277

CITY OF BALTIMORE: (No. ..... ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Hagadd

(Residence in Baltimore: No. 416 N. Exeter St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1872 (Year)

7-AGE, 49 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St.

15- NOV 3 — 1921 ROBERT A KRAUTER Registrar.
Filed ..... 191... Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2 (Month) (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Nov 2 1921, that I saw h in alive on Nov 2 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ..... 2 yrs. ..... mos. ..... ds.

(Signed) Rosinberg M. D.

11/3/21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 1 ds. In the State 30 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1416 N Exeter st

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cemetery — DATE OF BURIAL, 11-3-, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Balto. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58278

CERTIFICATE OF DEATH.

64 D 58278

REGISTERED NO.

1-PLACE OF DEATH Aylesburton apt- E. 2

CITY OF BALTIMORE: (No. Fairview Ave St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Worthington Jr

(a) RESIDENCE. No. 3804 Fairview Ave Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G. Worthington

6 DATE OF BIRTH (month, day, and year) May 30 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	68	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Glenburnie Farm
(State or country) Prince Georges County

PARENTS

10 NAME OF FATHER H. F. Worthington Jr

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Anne Arundel County

12 MAIDEN NAME OF MOTHER Ellen Hall Corbett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore City
(State or country)

14 Informant Miss E. Bridges
(Address) 3744 Piedmont Ave

15 Filed NOV 3 - 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...
that I last saw h... alive on June 1 1921
and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (apoplexy)

(4½ attack) died in 1 hour.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) more than 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical B.P. 220 mm Hg

(Signed) Charles O Donnell M. D.

Nov 2 1921 (Address) 3 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 4 '21

20 UNDERTAKER Henry H Jenkins & Sons Co

ADDRESS Orchard & McCulloh Sts

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Kazimera or Cazem Zidulis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58279

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cazen Zidulis

(a) RESIDENCE. No. 36 South Fremont Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Zidulis

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Kazemer Genaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Elezabeth Kalenskas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant John Zidulis

(Address) 36 So Fremont ave

15 NOV 3 - 1921 J.E.W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, 19 21, to Nov 1, 19 21, that I last saw her alive on Nov 1, 19 21, and that death occurred, on the date stated above, at 4:10 A m.

The CAUSE OF DEATH* was as follows:

Celampsia 0782

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis of respiratory center

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Nov 1, 1921

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo. L. Wenig, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 5 1921
20 UNDERTAKER	ADDRESS
John Grabliauskas	425 S. Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Authorized by Dr J. T. Hennessy
Geo. L. Wesley M. D

Puerperal Eclampsia
Operation for eclampsia

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58280

CERTIFICATE OF DEATH.

42 D 58280

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. University Hospital · St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Kleidel

(a) RESIDENCE. No. 1924 W. North Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winfield Kleidel

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. W. 000

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis Schatt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Eliz. Bunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Wm Kleidel
(Address) 1924 W North Ave

15 Filed NOV 3 - 1921, 19

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1- 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1921, to Nov 1, 1921, that I last saw her alive on Nov. 1, 1921, and that death occurred, on the date stated above, at 12:35 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation -

(duration) - yrs. - mos. 3 ds.

CONTRIBUTORY (Secondary) Senile Pruritus Carcinosis secondary to uterine Carcinoma.

(duration) yrs. 9 - mos. ds.

18 Where was disease contracted if not at place of death? St Louis

Did an operation precede death? Yes · Date of Oct. [illegible]

Was there an autopsy? Yes -

What test confirmed diagnosis? Microscopic -

(Signed) L. H. Brueback, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 4 1921
20 UNDERTAKER	ADDRESS
Martin Faherty & Sons	1827 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58281

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — From Northern Police District

REGISTERED No. C

CITY OF BALTIMORE (No. Unknown ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, about Oct 30, 1921 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- JOHNS HOPKINS HOSPITAL

Filed ....., 191.... Registrar.

NOV 3 - 1921 ROBERT A KRAUSE

Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, about Oct 30, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquest) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquest) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Thomsen M. D. (Coroner.)

Nov 1, 1921 (Address) 3693 Reisterstown Road

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

Commissioner of Health.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58282 CERTIFICATE OF DEATH. 89 D 58282

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 1310 Pennsylvania Ave. St.: (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Mollaye

(a) RESIDENCE. No. 1310 Pennsylvania Ave. St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9th 21

7 AGE Years: 3 weeks Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —0—

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Austin Mollaye

11 BIRTHPLACE OF FATHER (city or town) "Panama"
(State or country) "Florida"

12 MAIDEN NAME OF MOTHER Lula Harrod

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Anne Arundel Co.

14 Informant Mother
(Address)

15 FILED NOV 3 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1921

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,
that I last saw h alive on , 19 ,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. K. Bond M. D.

. 19 (Address) 310 Woodbrook Ave. Health Officer

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL | DATE OF BURIAL: NOV 2 1921

20 UNDERTAKER: Commissioner Health. | ADDRESS

For Wm. F. Wood

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58283

CERTIFICATE OF DEATH.

D 58283

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 McCulloh ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Keaton

(a) RESIDENCE. No. 1100 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 30-1921

7 AGE	Years	Months	Days	If LESS than 1 day 5 hrs. or min.
.	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Louis Keaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Horsepath S. Carolina

12 MAIDEN NAME OF MOTHER Mattie Madison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Horsepath S. Carolina.

14 Informant
(Address)

15 NOV 3 - 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1921, to Oct. 30, 1921, that I last saw him alive on Oct. 30, 1921, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	NOV 2 1921
20 UNDERTAKER Commissioner Health	ADDRESS

18540

Per. Wm. E. Woodall

GIVE THIS CERTIFICATE OF RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

131674 D 58284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X74 D 58284

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward L. Gardner

(a) RESIDENCE. No. 811 Virginia Ave. Fairmont W. Va.
(Usual place of abode) ST. WARD.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or WIFE) Jennie Gardner

6 DATE OF BIRTH (month, day, and year) Aug 2nd ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Henry Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Caroline Frechorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed NOV 3 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 29th, 1921, to Nov 3rd, 1921, that I last saw him alive on Nov 3rd, 1921, and that death occurred, on the date stated above, at 1:25 A. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Nov 2, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil J Holman, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethesda Pa	11/3/21
20 UNDERTAKER	ADDRESS
J Ahern & Co.	221 N Broadway

REMARK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58285

CERTIFICATE OF DEATH.

64 D 58285

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James C. Thompson

(a) RESIDENCE. NO. 1711 Maryland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec 27, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Granite Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) " " 675

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Darby Thompson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie O'Neill

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Keepers of Mt Hope Retreat
(Address) Mt Hope Md

15 Filed NOV 3 - 1921 ROBERT J. LAUTER Registrar

Asst. [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1917, to Nov 1, 1921, that I last saw him alive on Nov 2, 1921, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Sept 1 yrs. To date 11 mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Charles G. Hill, M. D.

, 19 (Address) At Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/4 1921
20 UNDERTAKER	ADDRESS
H. W. Meads & Son	805 N. Calvert St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

D 58286 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58286

105

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 526 W. Lanvale ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Johnson

(Residence in Baltimore: No. 526 W. Lanvale St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, Sept. 25, 1892
(Month) (Day) (Year)

7-AGE, 29 yrs. 1 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bell Boy
(b) General nature of industry, business, or establishment in which employed (or employer): 686

9-BIRTHPLACE, (State or Country), Norfolk, Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Henrietta Cook.

(Address) 526 W. Lanvale St.

15- Robert F. Harrison,

Filed ..... 191 Burial Permit Clerk, ... Registrar.

OV 3 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH November 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Auto Dilatation of Heart

(Duration) ..... yrs. ..... mos. 5 ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Nov. 3, 1921 (Address) 702 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cathedral	Nov 4 1921
20-UNDERTAKER Geo. W. Holland	ADDRESS 1631 Eutaw Pl

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58287

CERTIFICATE OF DEATH.

170 D 58287

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 E. Chase st ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia L. McCarthy

(a) RESIDENCE. No. 813 E. Chase st ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed,~~ or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph. E. McCarthy

6 DATE OF BIRTH (month, day, and year) Jan 7 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick Gissrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Regina Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Joseph. E. McCarthy 813 E Chase st

15 Filed Robert P. Harrison, Registrar

OVER 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2 — 1921, to Nov. 1 — 1921, that I last saw her alive on November 1, 1921, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) — yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

11/3/1921 (Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Nov 4 1921
20 UNDERTAKER	ADDRESS
Jos Joerchens Son	217 S. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58288 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58288

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 W Fort St. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Boehlein

(a) RESIDENCE. No. 140 W Fort ave ST. 23 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Boehlein

6 DATE OF BIRTH (month, day, and year): Feb 28 1862

7 AGE — Years: 59 — Months: 8 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman 186

(b) General nature of industry, business, or establishment in which employed (or employer): Stationary

(c) Name of employer: Con Gas Co.

9 BIRTHPLACE (city or town) (State or country): Wis

PARENTS

10 NAME OF FATHER: Chris. Boehlein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wis

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mrs M. Boehlein

(Address): 140 W Fort ave

15 [illegible] Rob. P. Harrison, Registrar

11-3-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to Nov 1, 1921, that I last saw h[illegible] alive on Nov 1, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Ephanthan

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. L. Campbell M. D.

Nov 2, 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Nov 4 1921
20 UNDERTAKER	ADDRESS
Mrs E Evans & Sons	428 Church

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 58289 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58289

CERTIFICATE OF DEATH.

172

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt. Geo. Hosp St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bigswell Rathers

(Residence in Baltimore: No. 1018 N. Durham St St.; yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 7, 1894
(Month) (Day) (Year)

7-AGE, 29 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Co.,

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Richard Rathers

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Henrietta Oliver

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Jones

(Address) Sparrows Point, Md

15- Nov 3 1921, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

12 hrs (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental Burden Steel Co,

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov 3, 1921 (Address) 7 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Bethlehem Steel Co. Homans Pier

Former or usual residence 1018 N. Durham St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Crewe Va	Nov 4, 1921
20-UNDERTAKER	ADDRESS
John W Henderson	E Monument St

Nov 3 - 1921

8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58290

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Patapsco ave (Brooklyn) ST.; 25-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Schaefer

(Residence in Baltimore: No. 327 Patapsco ave St.; life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 9, 1873
(Month) (Day) (Year)

7-AGE, 47 yrs. 11 mos. 23 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Office Work
(b) General nature of industry, business, or establishment in which employed (or employer): 660

BIRTHPLACE, (State or Country) Baltimore

10-NAME OF FATHER, Frederick Schaefer

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Carrie Bergheimer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Duckstein

(Address) 327 Patapsco Ave

Robert P. Harrison, 1921
Registrar.

921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1921, to Nov 2 1921, that I saw h— alive on Nov 1 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia, Lobar

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. T. Parran M. D.

Nov 2, 1921 (Address) 1900 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem — DATE OF BURIAL, Nov 4th, 1921

20-UNDERTAKER J. Schlosman & Son — ADDRESS 1039 Hanover St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58291

CERTIFICATE OF DEATH.

79 D 58291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2906 Philadelphia ave (Ward) 6 St.,

2-FULL NAME Louis Inarucci

(a) RESIDENCE NO. 2906 Phila. ave ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1914

7 AGE — Years: 7 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Tony Inarucci

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmella Lamorisco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Tony Inarucci
(Address) 2906 Phila ave

15 Filed NOV 4 - 1921

16 ROBERT A KRAUTER Registrar

Burial Permit 61818

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Nov 1, 1921, that I last saw h[illegible] alive on Nov 1, 1921, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows: Valvular (Mitral) Dis of Heart

(duration) one yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Tonsilitis & Rheumatism at various times (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? O Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual and Consultation

(Signed) Chas O'Donnell, M. D.

19 (Address) 1 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL 11-4-1921

20 UNDERTAKER J. J. Moran — ADDRESS 300 E Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58292

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 N Fayette ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Leon

(a) RESIDENCE. No. 1423 N. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Leon

6 DATE OF BIRTH (month, day, and year) Unknown 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pawn Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Leon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Benjamin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jacob Leon
(Address) 1722 Wyoming St

15 FILED NOV 4 - 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15. 1921, to Nov. 2, 1921, that I last saw him alive on Nov. 1. 1921, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Myocarditis (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) old age + Exhaustion. (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert C. Blake M. D.

. 19 (Address) 1014 N. Fayette.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 4 1921
20 UNDERTAKER	ADDRESS
John O'Mitchell	1221 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58293

CERTIFICATE OF DEATH.

175-001

D 58293

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John H. Long

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): 087

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo J Ruth

(Address) 1735 Hanford ave

15- NOV 4 - 1921 ROBERT J. KRAUTER Registrar

FOR Burial Permit ISSUED

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, OCT 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Fowler M. D.
(Coroner.)

11-4-1921 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Nov 4, 1921

20-UNDERTAKER George J Ruth

ADDRESS 1735 Hanford ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58294

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1058 S. Charles St. ST.; 22 WARD) 79 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louis Herman.

(Residence in Baltimore: No. 1058 S. Charles St. 52 -- 6 -- 8. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, April 25th, 1869. (Month) (Day), 1 (Year)

7-AGE, 52 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Furniture
(b) General nature of industry, business, or establishment in which employed (or employer)..... Salesman

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Louis Herman.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Barbara Goldsmith.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Herman.(sister).

(Address) 1058 S. Charles St.

15-

Filed NOV 4 - 1921 MORRIS A. KRAUTER Registrar.

Burial Form 1 01 66

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 2nd 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstruction Disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

Nov. 2nd., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oheb Sholom	Nov. 4., 19.21
20-UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58295

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58295

CERTIFICATE OF DEATH.

X 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2036 E Hoffman ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank C. Legro

(a) RESIDENCE. NO. 2036 E Hoffman ST., WARD. Pittsburg-Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalie Legro

6 DATE OF BIRTH (month, day, and year) Edmondson.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Penn.

9 BIRTHPLACE (city or town) (State or country) Pittsburg

PARENTS

10 NAME OF FATHER Frank S Legro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Rosalie Legro

(Address) 2036 E Hoffman Dd

15 Filed NOV 4 - 1921 BUREAU OF VITAL STATISTICS Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1921, to Nov. 2, 1921, that I last saw he alive on Nov 2, 1921, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William J Rymer, M. D.

(Address) 801 Wilkinswood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov. 5 1921

20 UNDERTAKER Frank Ernst & Son — ADDRESS 1906 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58296

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 George ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Lewis

(a) RESIDENCE. NO. 748 George ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James. Lewis

6 DATE OF BIRTH (month, day, and year) Aug 3 92

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Alfred Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Bagwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant Mary Lewis

(Address) 748 George St

15 NOV 4 - 1921 ROBERT J. KRAUSS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1921, to Nov 1, 1921, that I last saw her alive on Nov 1, 1921, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

1a. Pulmonic Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Clin

(Signed) Frank E. Simpson, M. D.

Nov 2, 1921 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov 5 1921
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Callie P. Johnson ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58297

CERTIFICATE OF DEATH. 1 1920

D 58297

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Pennington Av ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Callie Pierce Johnson

(a) RESIDENCE. No. 3710 Pennington Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, ~~and year~~) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER Geeje. C. S. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chules. Cuty md

12 MAIDEN NAME OF MOTHER Martha Whitehurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Florida

14 Informant: John. Johnson
(Address) 298 Bond Bldg Washington D.C.

15 Filed NOV 4 - 1921 ROBERT A. FRAZIER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Nov 3 1921,
that I last saw h~~e~~r alive on Nov. 3 1921,
and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - myo.
carditis - ~~acute~~ pneumonia
Nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) myo-carditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) W. S. Tublett, M. D.

19 (Address) Nov. 3-21 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Nov 4 1921
20 UNDERTAKER	ADDRESS
Jos Soerdens Son	217 E Pen

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1066 Bks.

D 58298 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58298

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Orleans ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret B. M. Yent

(a) RESIDENCE. NO. 1906 Orleans ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14/1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Arthur Yent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie E. Winterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mamie E. Yent

(Address) 1906 Orleans St.

15 Filed NOV 4 - 1921, 19.. ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1921, to Nov. 1st, 1921, that I last saw her alive on Nov 1st, 1921, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Analysis of Urine

(Signed) Alfred A Bendick, M. D.

19 (Address) 8 E. Pattison Park Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Nov 5 1921

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—U. P. Co.—1000 Bks.

D 58299

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 McCulloh ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Ridley

(a) RESIDENCE. NO. 1112 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Ridley

6 DATE OF BIRTH (month, day, and year) 1871 July 4th

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer Don't Know

9 BIRTHPLACE (City or town) Don't Know in Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER ~~Emorkie~~ West Sarah

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Beatrice Riley Daughter
(Address) 1112 McCulloh St

15 Filed NOV 4 1921 ROBERT J. BRAGER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3d 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1921, to Nov 3d, 1921, that I last saw her alive on Nov 2d, 1921, and that death occurred, on the date stated above, at 4 a — m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Not Known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) Samuel A Bain M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 7 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Av

Form 1—Rev. 1921

Be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58300

D 58300

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Ensor St ST., 10 WARD)

2-FULL NAME Abraham Hill

(a) RESIDENCE NO. 732 Ajax St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband. Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 017

(b) General nature of industry, business, or establishment in which employed (or employer) Minister

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D C born in Balt- 6-0 Years

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Louisa Hill (Address) 732 Ajax st Baltimore

15 Filed NOV 1 1921 ROBERT I KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4 - 1921 to Nov. 2 1921 that I last saw him alive on November 2 1921 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Bright Disease & Complication of Disease (duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Bright Disease & Complication Disease (duration) 1 yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Hall Kennard M.D.

11-3 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Nov 4 1921

20 UNDERTAKER Wm. R A. Elliott

ADDRESS 1775 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 13 84 D 58301

D 58301

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.) 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Chandler

(a) RESIDENCE. NO. 117 Hamburg St. City ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Floyd Chandler (Husband) 117 Hamburg St. City.

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H'Work.

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) lin in Balt-5 years Norfolk Va Md.

PARENTS

10 NAME OF FATHER Indian Grandy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) NC Md

14 Informant JOHNS HOPKINS HOSPITAL. Records

(Address)

15 Filed NOV 4 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1921, to Nov. 2, 1921, that I last saw her alive on Nov. 2, 1921, and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency.
Myocardial Insufficiency
Luetic Aortitis

* (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W B Herman, M. D.

11-2, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL Novem 4 1921

20 UNDERTAKER Mrs Robert-A Elliott — ADDRESS 1725 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58302

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 S Parrish St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara M. Booker

(Residence in Baltimore: No. 307 S Parrish St; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	married

6-DATE OF BIRTH, May 13, 1857
(Month) (Day) (Year)

7-AGE, 64 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Conrad Regler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Ecdl

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph L. Booker

(Address) 307 S Parrish St

15- NOV 4 - 1921

Filed ....., 191... L. E. Helm Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Nov 1 1921, that I saw her alive on Nov 1 1921, and that death occurred, on the date stated above, at 8:15 m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edgar B. Brayer M. D.

Nov 2, 1921 (Address) 1520 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Dorsey Run	Nov 5, 1921.
20-UNDERTAKER Harry A. Vidzke	ADDRESS 1031 W Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58303

CERTIFICATE OF DEATH.

D 58303

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2242 E. Fairmount ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Sheng

(Residence in Baltimore: No. 2242 E Fairmount Av St.; ..... yrs., ... mos. 4 hrs da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: Chinese

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Baby

6-DATE OF BIRTH: Nov. (Month) 2 (Day), 1921 (Year)

7-AGE: ..... yrs. 4 hrs mos. ..... ds.
If LESS than 1 day, ... hrs. or 4 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Jon Sheng

11-BIRTHPLACE OF FATHER (State or Country): China

12-MAIDEN NAME OF MOTHER: Yee Jo Suey

13-BIRTHPLACE OF MOTHER (State or Country): China

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- NOV 4 - 1921 Filed ....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 2 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 1921, to ..... 191..., that I saw h[illegible] alive on Nov 2 1921, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows: Prematurity 1mth

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. V. Kelly M. D.

Nov 2, 1921 (Address) 1100 N. Linwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, [illegible] PUBLIC CEMETERY.

DATE OF BURIAL, ..., 191...

20-UNDERTAKER [illegible] Commissioner Health.

ADDRESS 1921

[illegible] WOODALL NOV

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58304

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Fallsway & Pratt St ST.: 4 WARD)

2 FULL NAME Michael McCluskey

(Residence in Baltimore: No. ..... St.; yrs., mos. ds.)

1816 D 58304

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Every Item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	widower

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Orderly
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed NOV 4 - 1921 191.....

RECEIVED & ABSTRACTED
Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and autopsy thereon and from the evidence obtained by said Inquest, autopsy or inquiry found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cancerous brain, Coma & shock

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Oct 22, 1921 (Address) 1059 Bush

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: PUBLIC CEMETERY.

DATE OF BURIAL: NOV 1921, 19....

20-UNDERTAKER: Wm. B. Woodall

ADDRESS: City Please Burn

McCarthy 37 W Preston St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58305

D 58305

CERTIFICATE OF DEATH.

63

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 327 N. Stricker (St.:) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Schwarz

(a) RESIDENCE. No. 327 N Stricker St.. Ward.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Werner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Schwarz

(Address) 327 N Stricker St

15 Filed NOV 4 - 1921 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 1921 to Nov 2 1921

that I last saw her alive on Nov 2 1921

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Progressive Central Muscular Atrophy—

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H McCarthy, M. D.

, 19 (Address) 37 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 5th 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58306 D 58306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Vincent Asylum St. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta Kuser

(a) RESIDENCE. No. St Vincent Asylum ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant St Vincent's Asylum (Address) 401 Dawson St

15 Filed NOV 4 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to Nov 2, 1921, that I last saw her alive on Nov 2, 1921, and that death occurred, on the date stated above, at 1:20 m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis F Clauder M. D.

Nov 3, 1921 (Address) 15 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae	Nov 4 1921

20 UNDERTAKER ADDRESS

Wm Fahey & Sons 1827 W Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58307

CERTIFICATE OF DEATH.

79 D 58307

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Brown

(a) RESIDENCE. No. 736 Pierce St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed NOV 4 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1921, to November 2, 1921, that I last saw her alive on November 2, 1921, and that death occurred, on the date stated above, at 11:15 Am.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, myocardial insufficiency, pul monary oedema

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S. T. Wallis Lull, M. D.

11/3/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cmty	Nov 4 1921
20 UNDERTAKER	ADDRESS
George H. Hollang	1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58308

CERTIFICATE OF DEATH.

D 58308

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE (No. ..... ST.: 76 WARD) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Meite

(a) RESIDENCE. NO. Unknown ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

Ditto.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bayview Hospital

(Address) Baltimore, Md.

NOV 4 - 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1921 to Nov. 2, 1921

that I last saw h alive on Nov. 1, 1921

and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Brain Disease

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) N. Fredericks, M. D.

11/7/1921 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

Commissioner Health.

NOV 7 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58309

D 58309

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 N. Brice St. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M. McCarthy

(Residence in Baltimore: No. 3330 Edmondson Ave St.; 55 yrs., 10 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH June 16, 1866, (Month) (Day) (Year)

7-AGE. 55 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House wife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John C. Dacon

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Isabel Taylor.

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. McCarthy

(Address) 3330 Edmondson ave

15- NOV 4 - 1921 ROBERT J. BAUER Registrar.
Filed ....., 191.... Burial .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov - 2 -, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1921, to Nov 4 1921, that I saw h[er] alive on Nov 1 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilitation

(Duration) 4 yrs. 0 mos. few hours ds.

(Signed) Chas. Hyland M. D.

Nov 3, 1921. (Address) Charlestown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery. DATE OF BURIAL. Nov. 5, 1921.

20-UNDERTAKER George J. Smith ADDRESS 1068 Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58310 — 130

D 58310 — REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 900 Lakewood Ave St. | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gracella Beard

(a) RESIDENCE NO. 900 Lakewood Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles T Beard

6 DATE OF BIRTH (month, day, and year): Jany 23 1897

7 AGE: Years 24 Months 9 Days 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business, or establishment in which employed (or employer): Attorney

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Conrad Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Detmold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Chas T Beard 900 Lakewood

15 NOV 4 - 1921 ROBERT A ILAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Nov 3, 1921, that I last saw h e alive on Nov 2, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchy. Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Dilated heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Meany M. D.

11/4, 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ch Mathews Cem. — DATE OF BURIAL: Nov 5 1921

20 UNDERTAKER: J. Pearce Sons — ADDRESS: Norham

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks. (Lewis)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58311 — 29 ~ D 58311

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Park View Terrace ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis E. Chant

(Residence in Baltimore: No. 2804 Park View Terrace St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Aug. 19, 1846 (Month) (Day) (Year)

7-AGE, 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 043
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant Keeper

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Chant

(Address) 2804 Park View Terrace

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 1921, to Nov 3 1921, that I saw him alive on Nov 2 1921, and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Arch Fever Dropsy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 2 yrs. mos. ds.

(Signed) C. H. Duncan M. D.

Nov 3, 1921. (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Nov 3, 1921

20-UNDERTAKER Wm Cook ADDRESS 5026 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. See instructions on back of certificate.

Spec—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58312

CERTIFICATE OF DEATH.

D 58312

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Valdris O'Mailey.

(a) RESIDENCE. No. 710 N. Luzerne St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 0 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John O'Mailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rose Herman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John O'Mailey
(Address) 710 N. Luzerne Ave

15 Filed 4-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1921, to Nov 4, 1921, that I last saw her alive on Nov 3, 1921, and that death occurred, on the date stated above, at 4:05 a m.

The CAUSE OF DEATH was as follows:

Diphtheria, nasal, Tonsillar & pharyngeal

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) Bella Cowan, M. D.

11/4/21 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemetery	Nov 5 1921
20 UNDERTAKER: STEWART & MOWEN COMPANY, WILLIAM F. MOWEN, Successor	ADDRESS: [illegible] W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-9-19—H. P. Co.—1000 Bks.

D 58313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58313

CERTIFICATE OF DEATH.

154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N Payson St. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Smith

(a) RESIDENCE. NO. 401 N Payson ST. W WARD. 2

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Smith

6 DATE OF BIRTH (month, day, and year): Feb 22 1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Samuel Empat

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Keefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): J. J. Eberhardt 2238 Edmondson Ave

15 Filed 4-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1915, to Nov 1st, 1921, that I last saw h alive on Oct 28/21, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Weakness

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy Dulany, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Back Cem

DATE OF BURIAL: 11/24/19

20 UNDERTAKER: Geo C Fulton & Son

ADDRESS: Sykesville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

OV

Spec.—1-10-21—M&T—1500 Bks.

See affadavit Dover

D 58314

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

D 58314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 W Baltimore ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Walter Jr.

(a) RESIDENCE No. 1833 W. Balto. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace E. Walter

6 DATE OF BIRTH (month, day, and year) Oct 6-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52, ~~53~~	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector 086

(b) General nature of industry, business, or establishment in which employed (or employer) Baker Supply Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Chas. H. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Blackburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Grace O. Walter

(Address) 1833 W. Baltimore St.

15 Filed ..... 19 Robert P. Harrison, Registrar

4 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1921, to Nov. 2nd, 1921, that I last saw h alive on Nov. 2nd, 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bright's disease of Kidneys and Granular Degeneration of arteries, high blood pressure (duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Heart Paralysis (duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Test by acid test

(Signed) Jas. Homer Hoffman, M. D.

19 (Address) 180 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 11-5-1921

20 UNDERTAKER E. J. Doran — ADDRESS 300 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, state number of hours or days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

GENERAL AFFIDAVIT — The Daily Record Prin

State of Maryland, Baltimore City **to wit:**

BE IT REMEMBERED, *That on this* 8th *day of* December *A. D., 1921, before me the subscriber, a* Justice of the Peace *of the said state, in and for the* City *aforesaid, personally appeared* J. Homer Hoffman M. D. *Residing* 1809 Bolton Street Balto Md *and made oath in due form of law that* Charles H. Walter Jr. was born October 15th 1869 and by Error of the Undertaker his age was placed 53 years of a in the death certificate correct age 52 years

Signature

J. Homer Hoffman M. D.

Julius G. Gluck

MY COMMISSION EXPIRES MAY 2,

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58315

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1 N Vincent Ave St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Agnes Reinhardt

(a) RESIDENCE. No. 1 N Vincent Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. Life mos., ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27-1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Joseph Reinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Expires Soon

(Address)

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

4-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 19

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1921, to Nov 3, 1921, that I last saw h er alive on Nov 2, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Twin)

(duration) yrs. 3 mos. 11 ds.

CONTRIBUTORY (Secondary) Enphemeritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin Pleasants M. D.

Nov 3, 1921 (Address) 15 N McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 5 1921
20 UNDERTAKER	ADDRESS
Jas. C. Miller	2834 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 ✓ D 58316

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Patapsco ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora M. Satterfield

(a) RESIDENCE. NO. 1309 Patapsco ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Satterfield

6 DATE OF BIRTH (month, day, and year) May 22 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29	5	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER David Haney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Louisa Seymour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant (Address) John Satterfield 1509 Patapsco ave

15 Filed Robert P. Harrison, Registrar

NOV 4-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to 11-3, 1921, that I last saw h.er alive on 11-3, 1921, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. M. Sutten, M. D.

11/4, 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Nov 5 1921
20 UNDERTAKER C. Schlomandon	ADDRESS 1039 Hanover

BEFORE SIGNING BE CAREFULLY SURE ALL ITEMS ARE COMPLETE. ANY ERROR OR OMISSION MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58317

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Craig

(a) RESIDENCE. No. 538 N. Bond St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed 11-4-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1921

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1921 to Nov. 2, 1921 that I last saw him alive on November 2, 1921 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde M. O'Neill, M. D.

11/3/1921 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury. Cem.	Nov 5 1921
20 UNDERTAKER	ADDRESS
Jos. M. Skinner	625 E. Fred

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58318

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58318

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Taylor

(a) RESIDENCE. NO. 245 S. Dallas st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 Years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED 186

(a) Trade, profession or particular kind of work Employe in

(b) General nature of industry, business, or establishment in which employed (or employer) Packing House

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Dixon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Ennols

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) M. T. H.

15 Filed NOV 5 - 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to Nov. 3, 1921, that I last saw her alive on Nov. 3, 1921, and that death occurred, on the date stated above, at 9.55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Badagliacca M. D.

11-3-21 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 5 1921
20 UNDERTAKER John H. Trader	ADDRESS 142 West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(William. T. Bailey)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58319

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. T. Bailey.

(a) RESIDENCE. NO. 2138 E. Oliver ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mrs Julia M. Bailey

6 DATE OF BIRTH (month, day, and year) Nov. 4 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proof reader

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Julia M. Bailey

(Address) ~~2138~~ 2138 E Oliver St

15 Filed ..... 19 ..... Registrar

V5 1921 ROBERT P. ... Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6 . 1921 to Nov 4 . 1921 that I last saw him alive on Nov 4 . 1921 and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuf.

Ascites.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach about 2 yrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Eschenwich, M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 7 192
20 UNDERTAKER Henry Houck Son	ADDRESS 130 E Eag ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58320

CERTIFICATE OF DEATH.

28 D 58320

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Whatcoat ST., 16 WARD)

2-FULL NAME. Blanche Fraction

(a) RESIDENCE NO. 1009 Whatcoat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Fraction

6 DATE OF BIRTH (month, day, and year) May 24, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 03

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER William Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Martha Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) aa Co Md

14 Informant William Henson

(Address) 1009 Whatcoat St

15 Filed NOV 5 - 1921 GLG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 2, 1921,

that I last saw her alive on Nov 1, 1921,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Fry M. D.

11/3, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemetery.

DATE OF BURIAL Nov. 5 1921

20 UNDERTAKER James H. Dennis

ADDRESS 1303 Pennsylvania Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 58321

CERTIFICATE OF DEATH

120 D 58321

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3814 Ashburton ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Luttrell

(Residence in Baltimore: No. 3814 Ashburton Ave St.; 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6-DATE OF BIRTH: April (Month) 18 (Day), 1843 (Year)

7-AGE: 78 yrs. 1 mos. 16 ds. If LESS than 1 day, ... hrs., or .... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: John Luttrell

11-BIRTHPLACE OF FATHER (State or country): Va.

12-MAIDEN NAME OF MOTHER: Mary Dawson

13-BIRTHPLACE OF MOTHER (State or country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Dawson Luttrell

(Address) 3814 Ashburton

15-

Filed ..... 191 ..... Robert P. Harrison, REGISTRAR

5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to, Oct 2 1921, that I saw him alive on 11/2 1921, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
(Chronic Parenchymatous Nephritis)
(Duration) 2 yrs to my knowledge mos ds

Contributory (SECONDARY) Mitral Regurgitation
(Duration) 2 yrs to my knowledge mos ds

(Signed) Henry Russell M. D.

11/3 1921 [Address] 3902 Groveland Ct.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Nov 5 1921

20-UNDERTAKER: W M Rowton

ADDRESS 2238 N Howard

N.B.—Every question must be answered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58322

CERTIFICATE OF DEATH.

91 ✓ D 58322

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE? No. 220 S Payson ST.: 20 WARD)

2-FULL NAME James Morgan Clark

(a) RESIDENCE. No. 220 S Payson ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Clark

6 DATE OF BIRTH (month, day, and year) July 5th 1892

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Ice & Coal

(c) Name of employer American Ice Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sewell T Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Georgia Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Crumpton Queen Ann's Co

14 Informant Sewell T. Clark. (Address) 220 S. Payson St.

15 Filed NOV 5 - 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25th, 1921, to Nov 3rd, 1921, that I last saw him alive on Nov 3rd, 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H S Jane, M. D.

Nov 14, 1921 (Address) 720 W. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 7th 1921

20 UNDERTAKER Wm J. Hartwell ADDRESS 2236 W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58323 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 VD 58323

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1100 block n Myrtle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Davis

(Residence in Baltimore: No. 705 River St.,

St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, unknown, (Month) (Day) 1861 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Graves

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Davis

(Address) 705 River St.

15- NOV 5 - 1921 Filed, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 26 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy (Coroner.) M. D.

Nov. 4, 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Calvary Cem. DATE OF BURIAL, Nov. 5, 1921

20-UNDERTAKER Daniel Heusler ADDRESS 518 N. Bridge St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 58324

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 Falls Rd ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emma Dixon

(a) RESIDENCE. NO. 234 Falls Rd ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of not given

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) (d)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md-

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) not given

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lydia Brown
(Address) 234 Falls Rd

15 Filed NOV 5 - 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1921, to Nov 4, 1921, that I last saw her alive on Nov 4, 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows: OVER

Ac. Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Edw. Short, M. D.

11/4, 1921 (Address) 1812 Druid Hill ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Barkhill Cem.	Nov 6 1921

20 UNDERTAKER Samuel Hensley ADDRESS 518 N Eutaw St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition. Not luetic
Not tuberculous.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58325 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58325

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Riverside Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Demernie McKay

(a) RESIDENCE. No. 1219 Riverside Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph McKay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie McKay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs C McKay
(Address) 1219 Riverside Ave.

15 Filed NOV 5 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/4, 1921.

17 I HEREBY CERTIFY, That I attended deceased from 5/1/21, 19, to 11/4/21, 19, that I last saw her alive on 11/4/21, 19, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 3 yrs. mos. ds.

acute CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) S. Edward Norris, M. D.

11/4, 1921 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ridge, St Marys Co Md.	Nov 6 1921
20 UNDERTAKER	ADDRESS
John J Fahey Sons.	1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58326

CERTIFICATE OF DEATH.

104 D 58326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 W Randall ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Hanna

(a) RESIDENCE. No. 120 W Randall ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Ed. R. Hanna

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Morgan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Ed. R. Hanna
(Address) 120 W Randall

15 Filed 19 Robert P. Harrison, Registrar

11-5-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1921, to Nov 4, 1921.

that I last saw h alive on Nov 4, 1921.

and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. R. Campbell M. D.

Nov 4, 1921 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill.	11-5 1921
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—M. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58327

CERTIFICATE OF DEATH.

D 58327

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Boone

(a) RESIDENCE. No.... Perry, Georgia ST., WARD. Perry Ga.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-21-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER W. O. Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Mattie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed 11-5-1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-2, 1921, to 11-5, 1921, that I last saw him alive on 11-5, 1921, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Brain abscess

Otitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? S. C

Did an operation precede death? yes Date of Nov 2

Was there an autopsy? yes.

What test confirmed diagnosis? operation

(Signed) J. L. Houghton, M. D.

, 19 (Address) Johns Hopkins Hospital, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Perry Ga	Nov 5 1921
20 UNDERTAKER Joseph Ahern	ADDRESS 224 Broad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V 5-1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history

Spec.—1-10-21—M&T—1500 Blks.

D 58328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58328

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Brunt ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry Pius Wade

(a) RESIDENCE NO. 1705 Brunt ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Mary O'Keatley

6 DATE OF BIRTH (month, day, and year) March 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Making Ice Cream

(b) General nature of industry, business, or establishment in which employed (or employer) 986

(c) Name of employer Jm Fisk

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Wade

11 BIRTHPLACE OF FATHER (city or town) Chas Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Anne King

13 BIRTHPLACE OF MOTHER (city or town) Chas Co
(State or country) Md.

14 Informant Annie Wade
(Address) 2126 Dennison St

15 Filed ..... 19 ..... Registrar

V5 - 1921 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1921, to Nov 5, 1921.

that I last saw him alive on Nov. 4, 1921,

and that death occurred, on the date stated above, at 3304 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

11/5, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Beata Cemetery	11/7 1921
20 UNDERTAKER J. E. Mulloy	ADDRESS
Balto, Md.	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58329

D 58329

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (ST.:) 4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hendricks

(a) RESIDENCE. (No.) 101 East Mulberry ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 31 1843

7 AGE: Years 78 | Months 2 | Days 3 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry James Hendricks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: — Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Hospital Records

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

V5

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1921, to Nov 3, 1921, that I last saw her alive on Nov 3, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No eye

What test confirmed diagnosis? Symptoms

(Signed) John J. Colton, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/7 1921
20 UNDERTAKER	ADDRESS
Felix B. Pyne	1021 Mulberry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 58330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58330

CERTIFICATE OF DEATH.

83

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2104 Wallbrook ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elgar M. Winterburn

(Residence in Baltimore: No. 2104 Walbrook Ave St.; 7 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, March 12, 1849
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
72 yrs. 7 mos. 16 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Silas Barnhart

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Catherine Herne

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Herman

(Address) 2104 Walbrook ave

15-

Filed ....., 191.....

5-1921 Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1921, to Nov 3 1921, that I saw h[er] alive on Nov 2 1921, and that death occurred, on the date stated above, at 8:30a m.

The CAUSE OF DEATH* was as follows:

1. Thrombo-Phlebitis of Femoral Vein

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Embolus

(Duration) ..... yrs. ..... mos. Just a few minutes ds.

(Signed) O. H. Burkel M. D.

Nov 3, 1921 (Address) 1817 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem.	Nov. 7, 1921
20-UNDERTAKER	ADDRESS
Harry W. Ehlen	W. Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58331

HEALTH DEPARTMENT—CITY OF BALTIMORE

1091

D 58331

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 Bank ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wilbert Diacont

(a) RESIDENCE. No. 1501 Bank ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John Hubert Deacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Theresa Eslinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Theresa Eslinger
(Address) 1501 Bank

15 Filed Nov 5 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1. 1921, to Nov 4 1921, that I last saw h alive on Nov 4 1921, and that death occurred, on the date stated above, at 2 2 m.

The CAUSE OF DEATH* was as follows:

Acute Illeo-Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr John G. Oerum, M. D.

Nov 4 1921 (Address) 35-4 Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Nov 1921
20 UNDERTAKER	ADDRESS
Wendell Dyffel & Son	378 Mmm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58332

CERTIFICATE OF DEATH.

X 115

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hans Bolstad

(a) RESIDENCE. No. S.S. Mendeville Norwegian Consul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor (Cook)
(b) General nature of Industry, business, or establishment in which employed (or employer) ...
(c) Name of employer

9 BIRTHPLACE (city or town) ...
(State or country)

PARENTS

10 NAME OF FATHER Louis Bolstad

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Norway

12 MAIDEN NAME OF MOTHER Martha Larsen

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country)

14 Informant Anna Engel
(Address) 19 South St

15 Filed ... 19... Robert P. Harrison, Registrar
11-5-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Nov 5, 1921, that I last saw h(im) alive on Nov 5, 1921, and that death occurred, on the date stated above, at 5:25 a. m.

The CAUSE OF DEATH* was as follows:

Obstruction of common Bile Duct by Cancer

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Hemorrhage Zopnea

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home (Hotel or Institution)

Did an operation precede death? yes Date of Oct-31, 21

Was there an autopsy? ...

What test confirmed diagnosis? Surg. Biopsy & Symptoms

(Signed) Edward Gilbert, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 6 1921
20 UNDERTAKER Rapp & Sons Inc	ADDRESS 17 W Pray

CAUSE OF DEATH in plain terms, so that it may be properly classified. FACT STATEMENT OF OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman*, (*b*) *Grocery; (a) Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Inflammation process as well as obstruction
No gall stones. No further history.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58333

CERTIFICATE OF DEATH.

159 D 58333

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out Nos. 18.)

FULL NAME Frieda Bilipinsky

(Residence in Baltimore: No. 717 E. Eager St., St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1895 (Year)

7-AGE, 26 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 097

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Baltimore St

15- NOV 6 - 1921 1921 ROBERT A. KRAUTER Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. K. Ormsby M. D. (Coroner.)

11-3, 1921. (Address) 11 E Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Mehren Int Cosmos DATE OF BURIAL, 11—6, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 58334

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Littleton C. Johnson

(Residence in Baltimore: No. 709 George St.; 75 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, (Month) Jan (Day) 31, (Year) 1842

7-AGE, 79 yrs. 10 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Church

9-BIRTHPLACE, (State or Country) Texas Md

PARENTS.

10-NAME OF FATHER, Littleton C. Johnson

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Jane Johnson

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Johnson

(Address) 709 George St

15-NOV 6 - 1921 Filed ....., 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Nov (Day) 2, (Year) 1921.

I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Nov 2 1921, that I saw h[im] alive on Nov 2 1921, and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. D. Hughes M. D.

Nov 5, 1921. (Address) 1413 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Nov 5, 1921

20-UNDERTAKER, Samuel Hemsley — ADDRESS 518 McCulloh St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58335

CERTIFICATE OF DEATH.

138 D 58335

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S. Montford ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances. Paluchi

(a) RESIDENCE. No. 619 S. Montford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul. Paluchi

6 DATE OF BIRTH (month, day, and year): Aug. 1-1895

7 AGE: Years 26 Months 3 Days 3 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Homework.
(b) General nature of industry, business, or establishment in which employed (or employer): at Home. 637
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Pawel. Gurbelski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Wiktrya Swigard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Wiktorya Gurbelska (Address) 619 S Montford

15 Filed NOV 6 - 1921 19 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 1921, to Nov 4 1921, that I last saw her alive on Nov 4 1921, and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows: Fetal

Eclampsia

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary): Nephritis (duration) ....yrs. ....mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Hyams M. D.

(Address) 804 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: Nov. 19

UNDERTAKER: Wm Faikowski

ADDRESS: 168 Eastern Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); ***Measles;*** *Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. *g., sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Puerperal

Spec.—1-10-21—M&T—1500 Bks.

Rhuzicka
506 E Pratt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58336

CERTIFICATE OF DEATH.

29 D 58336

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N. Fox ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Rauch

(a) RESIDENCE NO. 206 N. Fox ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: John H. Rauch

6 DATE OF BIRTH (month, day, and year): Oct 29-1872

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John H. Rauch

(Address) 206 N. Fox

15 Filed NOV 6 - 1921

ROBERT J. KRAUTER
Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11 4 1921

17

I HEREBY CERTIFY, That I attended deceased from 11-2-1921, to 11-4, 1921.

that I last saw her alive on 11-4, 1921

and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Rutenberg M. D.

11-4, 1921 (Address) 1009 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millmont Cemetery

DATE OF BURIAL: Nov 11 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58337

CERTIFICATE OF DEATH.

170 D 58337

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920, Light ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis F. Wood

(a) RESIDENCE. No. 1920 Light ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary V. Wood

6 DATE OF BIRTH (month, day, and year) July 28-1844

7 AGE: Years 77 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George H. Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Caroline Stivers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mary V. Wood. 1920 Light Street

15 Filed NOV 6 - 1921 19.. ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1921, to Nov 5, 1921, that I last saw him alive on Nov 5, 1921, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indeterminate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

Nov 6, 1921 (Address) 1646 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 7 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58338

CERTIFICATE OF DEATH.

D 58338

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 824 N Central Ave. (St.) 10 (Ward)

2-FULL NAME Julius Bierman

(a) RESIDENCE. No. 824 N. Central Ave. St., ... Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8. 12. 78.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	2	23	

8 OCCUPATION OF DECEASED 044

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) retired,

(c) Name of employer Wm. Bierman Balto. Md.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Louis Bierman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Rodman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wm. Burman
(Address) 824 N Central Ave

15 Filed NOV 6 - 1921 ROBERT N KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 5. 1921.

17 I HEREBY CERTIFY, That I attended deceased from November 3 1921, to November 5 1921.

that I last saw him alive on November 5 1921.

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

11 (Signed) Thos. B. A. Meyer M. D.

S. 19 21 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov 8th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 58339

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) University Hospital ST.: (S) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rogers — (Rodgers)

(a) RESIDENCE: No. 1819 N. Port St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mrs Pauline Rodgers.

6 DATE OF BIRTH (month, day, and year) Feb 7th 46

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 16 Y

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Consolidated Gas Elect. Lt. Co.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Matilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: University Hospital Records

(Address)

15 Filed NOV 6 - 1921 ROBERT R. KRAUTER Register

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1921, to Nov 4, 1921, that I last saw h~~im~~ alive on Nov. 4, 1921, and that death occurred, on the date stated above, at 9 ~~30~~ a m.

The CAUSE OF DEATH* was as follows:

Uremia with Chronic nephritis (Interstitial)

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Benign Hypertrophy of Prostate gland

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1819 - N. Port St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam. + Microscopic

(Signed) W. H. Jones, M. D.

11/7, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Nov 7 1921
20 UNDERTAKER: Philip Herwig	ADDRESS 2006 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58340

CERTIFICATE OF DEATH.

138 D 58340

1-PLACE OF DEATH West End Maternity

CITY OF BALTIMORE: (NO. 612 N Calhoun ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Marie Wilson

(a) RESIDENCE NO. 109 S Highland Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman Wilson

6 DATE OF BIRTH (month, day, and year) Mar 20/95

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Eugene Veith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa

13 ~~BIRTHPLACE OF MOTHER~~ (city or town) (State or country) Md

14 Informant Norman Wilson

(Address) 109 S. Highland

15 Filed NOV 6 - 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 5 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1921, to Nov 5, 1921, that I last saw h[illegible] alive on Nov 5, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Delivery

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 3013 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL Nov 8 1921

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Arlington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58341

CERTIFICATE OF DEATH.

9 D 58341

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Ravinski

(a) RESIDENCE. NO. 111 S. Collington Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none (0)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Ravinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Trimoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Joseph Ravinski 111 S Collington Ave.

15 Filed NOV 6 - 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30 1921, to Nov. 5 1921, that I last saw h[er] alive on Nov. 5 1921, and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar, pharyngeal & laryngeal.

(duration) yrs. mos. 9(?)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no cultures (+)

What test confirmed diagnosis?

(Signed) B Blackbaum M. D.

Nov 6 1921 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen Circle	Nov 6 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 58342

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S. Collington Av. ST., 5th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Flaherty

(Residence in Baltimore: No. 103 S. Collington Av. St.; 58 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, January 3, 1846
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
75 yrs. 10 mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Thomas Banks

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER Mary

13-BIRTHPLACE OF MOTHER (State or Country), Delaware or Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Flaherty

(Address) 103 S. Collington Av

15-
Filed NOV 6 - 1921 1921 ROBERT F. SLATER
Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 23 1921, to November 3 1921, that I saw h[illegible] alive on November 3 1921, and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward A. Bradick M. D.

Nov 5, 1921 (Address) 2 S. Patterson Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Cross Cemetery	11-7-1921

20-UNDERTAKER J. F. Moran ADDRESS 1000 E. Baltimore

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Each statement of fact important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58343

CERTIFICATE OF DEATH.

64 D 58343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 Portman ST. 15 WARD)

2-FULL NAME Bertha Ridgley

(a) RESIDENCE NO. 1507 Portman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: B.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Jasper Ridgley

6 DATE OF BIRTH (month, day, and year): May 27 1876

7 AGE: Years 45 Months 5 Days 8

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Housewife

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Harriet Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Viola Banks

(Address): 96 West Chase St

15 Filed NOV 6 - 1921 ROBERT P. LAMDEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27 1921 to Nov. 4 1921 that I last saw h alive on Nov. 3 1921 and that death occurred, on the date stated above, at 7 30a m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

15 Days

(duration) — yrs. — mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. M. Pelleman, M. D.

, 19 (Address) 829 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Nov 7 1921

DATE OF BURIAL

20 UNDERTAKER: Ellenbach

ADDRESS: 502 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Hoernlein

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58344

CERTIFICATE OF DEATH.

28 D 58344

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Louise Hoernlein

(Residence in Baltimore: No. 2231 Federal St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Single

6-DATE OF BIRTH. March 30, 1897 (Month) (Day) (Year)

7-AGE. 24 yrs. 7 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER. August Hoernlein

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Caroline Stumm

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

X (Informant) Caroline Hoernlein

(Address) 2231 Federal St

15-

NOV 6 - 1921

Filed....., 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 3 1921, to November 4 1921, that I saw her alive on November 4 1921, and that death occurred, on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

(a) Phlegmonous Endometritis

.....

.....

..... (Duration)...2... yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration)...2... yrs.....mos.....ds.

(Signed) J. Edward Ewing M. D.

Nov 5, 1921. (Address) 1613 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Balto Cem

DATE OF BURIAL. 11—8.., 1921

20-UNDERTAKER Mrs Chas A G Rohde

ADDRESS Harlington Ave

CAUSE OF DEATH must be plainly written, so that it may be understood. Every question must be answered if possible. Physician will please write plainly and fill out certificate in full. Informant will please read carefully the questions numbered 1 to 15, and answer each question as correctly and fully as possible. It is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58345

CERTIFICATE OF DEATH.

79 D 58345

1 PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 22 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George M. Nevakar.

(Residence in Baltimore: No. 18 E. Montgomery St. St.; 58 yrs., 8 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White,	Married

6-DATE OF BIRTH, February 22nd. 1863, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
58 yrs. 8 mos. 12 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Collector.
(b) General nature of industry, business, or establishment in which employed (or employer): O.T.V.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Peter Nevakar.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Mary C. Schafer.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Nevakar. (wife)

(Address) 18 E. Montgomery St.

15- Filed NOV 6 - 1921, 191.... ROBERT J KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3rd. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above. n/a

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) ..... M. D. (Coroner.)

Nov. 5th., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem.	Nov. 7, 1921
20-UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover St

N.B.—Every item of information should be carefully supplied. AGE must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58346 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 4 D 58346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 N Port ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Stanley Smith

(a) RESIDENCE. No. 1323 N. Port St ST., 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	X	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William H Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Grace E Pritchard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Wm. McElvain 1323 N Port St.

15 NOV 6 - 1921 ROBERT J. BRAGER Registrar Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1921, to Nov 6 1921, that I last saw him alive on Nov 6 1921, and that death occurred, on the date stated above, at 3.30 9 m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D P Herzog md M. D.

(Address) Nov 6 1921 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov. 7 1921
20 UNDERTAKER	ADDRESS
Henry Hoerth Son	1301 E Eager

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58347

CERTIFICATE OF DEATH.

37-092
D 58347

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.; 4 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kulzer.

(a) RESIDENCE. No. 119 Greene ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber. 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER John Kulzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Teresa Thock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Frank Kulzer
(Address) 3705 Germantown Ave. Phila Pa

15 NOV 7 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/31, 1921, to 11/5, 1921, that I last saw him alive on 11/5/21, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) ..... , M. D.

11/7, 1921 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	Nov 7 1921
20 UNDERTAKER	ADDRESS
Jos Saunders Son	217 S. Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Patient had severe myocardial insufficiency; aortic and mitral insufficiency, syphilitic aortitis - extend hepatic markedly aggravic - developed pulmonary edema.
acute lobar pneumonia

D 58348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Womens Hospital St.: 27 167 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Virginia Morton

(Residence in Baltimore: No. 4745 Park Heights Ave St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	single

6-DATE OF BIRTH, November, 1861
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo. C. Morton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maryann Packwood

13-BIRTHPLACE OF MOTHER (State or Country), La.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. P. Morton Jr.

(Address) 11 E. Chase St.

15-

NOV 7-1921 ROBERT J. KRAUTER

1921 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st, 2nd, 3rd degree burns of body (accidental)
(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism caught from burns.
(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov. 6, 1921 (Address) 2502 E. Fairmount Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Womens Hosp. In the of death.....yrs.....mos. 1 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
4745 Park Heights Ave.

Former or usual residence.....same.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Nov 7th, 1921

20-UNDERTAKER Henry A. Jenkins Sons

ADDRESS 2c Guilford Orchard

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58349

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH Renoak ave

CITY OF BALTIMORE: (No. Elderslie ave. ST.: Mt. Washington 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gertrude McColgan

(a) RESIDENCE. No. Renoak ave. ST. Mt. Washington WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 3rd 1821

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...000...

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward McColgan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Helen Vaughan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant M. Teresa McColgan
(Address)

15 Filed NOV 7-1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5-th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1921, to Nov 5, 1921, that I last saw h[illegible] alive on Nov 5, 1921, and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

...(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

...(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno. G. Dunn, M. D.

, 19 (Address) 8501 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 7 1921
20 UNDERTAKER Henry W. Jenkins Sons Co	ADDRESS McCulloh-Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58350

CERTIFICATE OF DEATH.

D K, 58350

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: No. 168 W ST.; 21 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Watts

(a) RESIDENCE. No. 204 Aisquith St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby. 200

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Annie Watts
(Address) 204 Aisquith St.

15 NOV 7 - 1921 ROBERT J. KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1921. to Nov 5 1921.

that I last saw her alive on Nov 5 1921.

and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Fracture right femur.
Respiratory failure.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ether Anaesthesia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 5, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus D Hamm, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rahmon Hebrew Assoc	11/7/21 1921
20 UNDERTAKER	ADDRESS
R L. Parham	648 N Eu

(Dr.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58351

CERTIFICATE OF DEATH.

64 D 58351

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Bolton ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Mathews

(a) RESIDENCE. NO. 1511 Bolton St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ink. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced (write the word)~~
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur Fisk Mathews.

6 DATE OF BIRTH (month, day, and year) April 2nd, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Bride

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Merrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Elizabeth B. Mathews

(Address) 1511 Bolton St

Filed NOV 7 - 1921 ROBERT J. KRAJEWSKI Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5th, 1921, to Nov. 6th, 1921, that I last saw her alive on Nov. 6th, 1921, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral effusion, causing right side hemiplegia. Duration of about 24 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

indeterminate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of X

Was there an autopsy? No.

What test confirmed diagnosis? General condition

(Signed) Elaine C. Price, M. D.

, 19 (Address) 101 E. Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 8th 1921

20 UNDERTAKER Bertram L. Gore

ADDRESS 1723 W. Fayette

D 58352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Scott St. BROOKR, St. 21 WARD) REGISTERED No. C 175-003

2-FULL NAME Theodore Pierson

(Residence in Baltimore: No. 1231 Scott St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov 24, 1913
(Month) (Day) (Year)

7-AGE, 12 yrs. 11 mos. 11 ds.

If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer)..... Boy

9-BIRTHPLACE, (State or Country), Balt md

PARENTS.

10-NAME OF FATHER, Abraham Pierson

11-BIRTHPLACE OF FATHER (State or Country), Balt md

12-MAIDEN NAME OF MOTHER Ella Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Balt city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Thompson

(Address) 1231 Scott St

15- Filed NOV 7-1921 ROBERT J. KRAUSER Registrar. Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Off St Car
Steam R.R., accident
Instantaneous

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Knowles M. D.
(Coroner.)

Nov 7, 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, Nov. 8, 1921.

20-UNDERTAKER John J Corcoran & Son — ADDRESS 901 Hollins St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 58353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 58353

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 S. Third ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reinhardt Heineman

(Residence in Baltimore: No. 1035 S. Third St.; 63 yrs., ~~5~~ mos. ~~11~~ da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 24 (Day), 1858 (Year)

7-AGE, 63 yrs. 5 mos. 11 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Broom factory

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Heineman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not-Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kunigunda Heineman

(Address) 1035 S. Third St.

15- NOV 7 - 1921 ROBERT J. KRAUTER

Filed....., 191... REGISTRAR.

CAUSE OF DEATH must be plainly stated, so that any physician may understand it. Do not use abbreviations or technical terms. Indefinite statements, such as "Disease of the heart," "Tumor," "Cancer," "Consumption," "Fever," "Child-birth," "Old age," are insufficient. Local names of diseases are unsatisfactory. Causes of death which may be the result of violence must always be fully explained. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 3 1921, to Nov. 5 1921, that I saw him alive on Nov. 5 1921, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. ....mos. 4 da.

(Signed) Geo. L. Zobelbach Sr. M. D.

Nov. 6, 1921. (Address) 846 S. Third St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oaklawn Cemetery

DATE OF BURIAL, Nov. 8, 1921

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58354

CERTIFICATE OF DEATH.

D 58354

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Penna Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Concetta Marzullo

(Residence in Baltimore: No. 2228 Penna ave St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem | 4-COLOR OR RACE, White | 5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) widowed

6-DATE OF BIRTH, 2-1-, 1848
(Month) (Day) (Year)

7-AGE, 73 yrs. 9 mos. 5 ds. | If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Salvatore Marino

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Michela Schittino

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Marzullo

(Address) 2228 Penna Ave

15-

Filed NOV 7-1921, 191... [illegible] Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11-5-, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July - 1916, to 11-5- 1921, that I saw h alive on 11-5- 1921 and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Cancer of the womb

..... (Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Stella M. D.

....., 191... (Address) 210 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Vincent Cem.	11 8 21, 191...
20-UNDERTAKER	ADDRESS
Geo J Ruth	1735 Hanford

CAUSE OF DEATH in plain terms, by which may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58355
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

91 D 58355
REGISTERED NO.

CITY OF BALTIMORE: (No. 1035 - Greenmount ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Anderson

(a) RESIDENCE No. 1035 - Greenmount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 7/23/1921

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
—	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Child 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Shedwig Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Co. Md.

12 MAIDEN NAME OF MOTHER Pearl Harman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md.

14 Informant Shedwig Anderson
(Address) 1035 - Greenmount Ave

15 FILED NOV 7 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1921, to Nov. 6, 1921, that I last saw him alive on Nov. 6, 1921, and that death occurred, on the date stated above, at 10.35 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

11/7, 1921 (Address) 1823 N. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 11/7/21 19

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58356

CERTIFICATE OF DEATH.

40 D 58356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Fleet ST., 2 WARD)

2-FULL NAME Casimir Jastkiewicz

(a) RESIDENCE NO. 1929 Fleet St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed or divorced (or) WIFE of Frances Jastkiewicz

6 DATE OF BIRTH (month, day, and year) Mar 4 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Jastkiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Michalina Antonczyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Francis Jastkiewicz

(Address) 1929 Fleet St

15 Filed NOV 7-1921 ROBERT A KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 30 to Nov 4 21.

that I last saw her alive on Nov 1 1921

and that death occurred, on the date stated above, at 230 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 3 21

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Wm. T. Kinsley, M. D.

19 (Address) 2488 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Nov 8 1921

UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58357

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 58357

REGISTERED No. C

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 22 WARD) 784

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Goodle.

(Residence in Baltimore: No. rear of 125 E. Hughes St. St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE, 60 yrs. ---------- mos. ---------- ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman. 166
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Bank.

(Address) 38 E. Montgomery St.

15- NOV 7-1921 Filed ....., 191.....

ROBERT I KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 4th, 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration and hemorrhage of the brain. Fracture of the skull due to external force by a blunt instrument (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Homicide. (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Nov 5th, 21 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds. 3 hours.

Where was disease contracted, if not at place of death? rear of 125 E. Hughes St.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Weber Westminster Md. DATE OF BURIAL, Nov 7, 19 21

20-UNDERTAKER A. Ellinger & Bro. ADDRESS 112 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1420 D 58358

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lojka

(Residence in Baltimore: No. 600 S. Ann St. St.; 27 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown — (Month) (Day), 1867 (Year)

7-AGE, 54 yrs. - mos. - ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pool room Opr
(b) General nature of industry, business, or establishment in which employed (or employer): and candy Store.

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jetka Lojka

(Address) 600 S. Ann St.

15-

Filed NOV 7 - 1921 191.... ROBERT A KRAUTER

Burial Permit Register

CAUSE OF DEATH to be written in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1921 191.... to October 21 191...., that I saw h[illegible] alive on October 2 1921, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) Years yrs. mos. ds.

(Signed) Frank A. Simonok M. D.

Nov. 6, 1921 (Address) 2430 Fait

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov. 8..., 1921.

20-UNDERTAKER W. J. Sadowski. ADDRESS 705 S. Ann

Montealti

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58359

CERTIFICATE OF DEATH.

182 D 58359

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1600 E Hoffman ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent-montealto.

(Residence in Baltimore: No. 1600 E. Hoffman, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, not known, (Month) (Day) 1 (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Road

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Montialto

(Address) 1600 E Hoffman St

15- Filed NOV 7 - 1921 ROBERT A KRAUTER Registrar Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach Cancer

6

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

11-6, 19, (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent — DATE OF BURIAL, N.V.T., 19

20-UNDERTAKER [illegible] — ADDRESS, 900 Highland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

34

D 58360

CERTIFICATE OF DEATH.

D 58360

REGISTERED NO. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 804 Hampden ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Johnson

(Residence in Baltimore: No. 804 Hampden St.; 25 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, 48 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer), Public

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriett Edmonds

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Johnson

(Address) Penfield, Md.

15- Filed NOV 7 - 1921 19.... ROBERT J. KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28th 1921, to Nov. 5th 1921, that I saw h[illegible] alive on Nov. 4th 1921 and that death occurred, on the date stated above at 4:40 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. 2 mos. ..... da.

CONTRIBUTORY (Secondary) Hypertension 4

(Duration) 1 yrs. 2 mos. 5 da.

(Signed) A. Jno. [illegible] M. D.

11/7, 1921. (Address) 924 Hamilton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Cupress Cem. DATE OF BURIAL, Nov. 7, 1921.

20-UNDERTAKER, Samuel Kemsley ADDRESS 57 E. Bel Air Ave.

CAUSE OF DEATH must be plainly and fully stated, and all questions answered so far as possible. Every certificate must be complete and correct in all important particulars. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58361

CERTIFICATE OF DEATH.

5-1052

D 58361

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

No. 312 Forrest ST.: 5 WARD)

2-FULL NAME Frank Thomas Dobson

(a) RESIDENCE. No. 312 Forrest ST., ..WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 058

(b) General nature of industry, business, or establishment in which employed (or employer) Originally, Shoemaker

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Georgia Dobson-Boston
(Address) 312 Forrest St

NOV 7-1921 [redacted] Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov- 2, 1921, to Nov- 4-, 1921, that I last saw him alive on Nov-4-, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Fermentation Gastro Enteritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gen Symptomatology

(Signed) Edw Short, M. D.

Nov 4 1921 (Address) 1812 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodberry Cemetery

DATE OF BURIAL Nov 7th 1921

20 UNDERTAKER Chas S. Bailey

ADDRESS 1720 Jefferson Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58362

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Women Home ST.: (19 WARD)

2-FULL NAME Sarah T Bevans

(a) RESIDENCE. No. 1400 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 25 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Snow Hill Md.

PARENTS

10 NAME OF FATHER: Wm Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country): Easton Md

12 MAIDEN NAME OF MOTHER: Elizabeth Atkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Easton Md

14 Informant (Address): Ella J Jones Matron

15 Filed NOV 7 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Nov. 5, 1921, that I last saw h.....alive on Nov 5, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Atheroma General

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? W F Norwood

(Signed) Nov 11 1921, M. D.

19 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 8 1921

20 UNDERTAKER: Geo J Smith

ADDRESS: W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58363 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 58363

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 Harlem ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Rollins

(Residence in Baltimore: No. 1512 Harlem ave St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. 29, 1841
(Month) (Day) (Year)

7-AGE, 79 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Florence A. Rollins

11-BIRTHPLACE OF FATHER (State or Country). Balto Co. Md.

12-MAIDEN NAME OF MOTHER Mary Ann Frazier

13-BIRTHPLACE OF MOTHER (State or Country). Cambridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence H. White

(Address) 1512 Harlem Ave

15- NOV 7 - 1921

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1st 191.., to Nov. 5 1921, that I saw h[illegible] alive on Nov. 2 1921, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Hemorrhage, from Bad Fever

(Duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) 2 yrs. mos. ds.

(Signed) H. Lakota Ewell M. D.

Nov. 7, 1921 (Address) 905 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Nov. 8, 1921
20-UNDERTAKER George J. Smith	ADDRESS 1000 Fayette St

CAUSE OF DEATH must be plainly written, so that it may be easily understood. All questions must be answered as far as possible. Every item is important. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58364

CERTIFICATE OF DEATH.

H 2

D 58364

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 811 Hanstead Pk (St.) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacqueline Amelia Daschiell.

(a) RESIDENCE. NO. 811 Hanstead Pk ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 0 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo H Daschiell

6 DATE OF BIRTH (month, day, and year) October 17th 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) — 027

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James H. Harker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jacqueline Meek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Co Md.

14 Informant (Address) George H. Daschiell 811 Hanstead Pk

15 Filed NOV 7 - 1921 19 ROBERT A. BRAUTIGAM Registrar Board of Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12th, 1931, to Nov 5th, 1931, that I last saw h[illegible] alive on Nov 5th, 1931, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma
of Uterus

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory exam

(Signed) Jos Hungerford M.D., M. D.

19 (Address) 4016 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Oak Lawn Cemetery Nov 9 1921

20 UNDERTAKER — ADDRESS

F B Heppert 2236 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58365

CERTIFICATE OF DEATH.

D 58365

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1611 Cole ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Steiger

(a) RESIDENCE. NO. 1611 Cole ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4-1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Rud Cramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Pelz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Storrie

(Address) 1611 Cole St.

15 Filed NOV 7 - 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1921, to Nov 5, 1921, that I last saw h.. alive on Oct 4, 1921, and that death occurred, on the date stated above, at 10 30 H m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) E. V. Cornbrooks, M. D.

11/6, 1921 (Address) 24 W Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 8 1921
20 UNDERTAKER	ADDRESS
Robt Turner Sons	N. Bway,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Holewincki

D 58366

HEALTH DEPARTMENT—CITY OF BALTIMORE

168-001

CERTIFICATE OF DEATH.

D 58366
REGISTERED No. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Church Home ST.; 1 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna Holewincki

(Residence in Baltimore: No. 1244 S. Ellwood St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October 21, 1917
(Month) (Day) (Year)

7-AGE, 4 yrs. 0 mos. 15 ds.
If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, Andrew Holewincki

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Anna Rosel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Andrew Holewincki
(Address) 1244 S. Ellwood Ave

15 Filed NOV 7-1921 191 ROBERT J KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Coroner
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxia Illuminating Gas.
Coal Illuminating Gas Suicide
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)
11/7, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?....
Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Nov. 8, 1921

20-UNDERTAKER Lilly & Zirkin. ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58367

HEALTH DEPARTMENT—CITY OF BALTIMORE

001
167 D 58367

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Church Home St. | WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C Holewinski

(Residence in Baltimore: No. 1244 S. Ellwood St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug. (Month) 30 (Day), 1911 (Year)

7-AGE, 9 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... attended
(b) General nature of industry, business, or establishment in which employed (or employer)..... school, ooo

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, Andrew Holewinski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Anna Roesel.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Andrew Holewinski
(Address) 1244 S. Ellwood Ave.

15- ROBERT J KRAUTER
Filed..... 191.. Registrar.
NOV 7-1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Asphyxia Illuminating Gas.
Used Illuminating Gas.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. Nath Hanley M. D.
(Coroner.)
11-8, 1921 (Address) Gilbert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Nov. 8, 1921

20-UNDERTAKER Tully and Jenkins ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58368

CERTIFICATE OF DEATH.

151 D 58368

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene St.: 4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thompson

(a) RESIDENCE. No. 1913 Frederick Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5-1921

7 AGE	Years	Months	Days	If LESS than 1 day, 18 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Thompson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Montgomery Co. Maryland

12 MAIDEN NAME OF MOTHER Lola Easton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Montgomery Co Maryland

14 Informant Mrs Lola Thompson
(Address) 1913 Frederick Ave

15 Filed . 19 ROBERT A. GRAUER
Registrar

NOV 7-1921 Burial Permit Issued 18655

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1921, to Nov. 6, 1921, that I last saw h( )r alive on Nov. 6, 1921, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity
(76 wks. foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

11-7-1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health
NOV 7 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 58369

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 2223 Christian ST. 20 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles MacKenzie

(Residence in Baltimore: No. 2223 Christian St.; yrs. 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH, April 29, 121
(Month) (Day) (Year)

7-AGE, 43 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION,
(a) Trade, profession, or particular kind of work: structural
(b) General nature of industry, business, or establishment in which employed (or employer): Iron worker

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, David MacKenzie

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ann Malloy

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel MacKenzie
(Address) 2223 Christian St

15- NOTED & ENTERED
Filed NOV 7 1921 1921 Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
(Duration) ....yrs. ....mos. 1 ds.
CONTRIBUTORY (Secondary) Acute Congestion of
(Duration) ....yrs. ....mos. ½ ds.
(Signed) James H Watson M. D.
(Coroner.)
Nov 6, 1921 (Address) 10 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	Nov 9, 1921
20-UNDERTAKER	ADDRESS
Geo L Schwab	1101 Eutaw Ave

N.B.—Every question should be carefully answered, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 58370

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3957 Roland Ave ST.: WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Lowman

(a) RESIDENCE. NO. 3957 Roland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m	w	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Virginia

6 DATE OF BIRTH (month, day, and year) June 3, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 74

(b) General nature of industry, business, or establishment in which employed (or employer) United Railways

(c) Name of employer Same

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. Lowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Tracey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William J. Lowman

(Address) 601 W. 33rd st.

15 Filed NOV 4 1921

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6 1921

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to November 6, 1921, that I last saw him alive on November 5, 1921, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Irwin E. Wagner, M. D.

11/6, 1921 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Nov 8 1921
20 UNDERTAKER	ADDRESS
Walter R. McNamara	Same

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Original Missing) D58370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3957 Roland Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Lowman

(a) RESIDENCE NO. 3957 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant

(Address)

15

Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1921

17

I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Erwin E Mager, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Druid Ridge Cemetery

DATE OF BURIAL
19

20 UNDERTAKER

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 58371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58371

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 W. Barre ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi M. Kilby

(a) RESIDENCE NO. 916 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert G. Kilby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Vola Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Robert G. Kilby (Address) 916 W. Barre st.

15 Filed , 19 Robert F. Hartbank Registrar

7-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1921 to Nov 7, 1921.

that I last saw h alive on Nov 6, 1921

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Duffington M. D.

(Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Nov 8 1921
20 UNDERTAKER	ADDRESS
James Dignum & Son	1000 S. Pac

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Walter Trexler)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58372

CERTIFICATE OF DEATH.

120 D 58372

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 E Preston ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Trexler

(a) RESIDENCE. NO. 1631 E Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Clara M. Trexler.

6 DATE OF BIRTH (month, day, and year) March 28-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Compositor 063

(b) General nature of industry, business, or establishment in which employed (or employer) Printing

(c) Name of employer Arthur Thompson Balto Md.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas T. Trexler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Miss Daisy Trexler.

(Address) 1631 E Preston St

15 Filed ....., 19.... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Nov 5, 1921, that I last saw h.. alive on Nov 4, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Heart failure, Tojemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H D Bullock, M. D.

, 19 (Address) 1623 E Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	11/8/21 19

20 UNDERTAKER J E Hughes ADDRESS 424 S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7-1091

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Farinaccio) (Clairmount Ave.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58373

CERTIFICATE OF DEATH.

137

D 58373

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3702 Clairmont Ave. ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Farinaccio

(a) RESIDENCE. No. 3702 Clairmont Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W. White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Antonio Farinaccio

6 DATE OF BIRTH (month, day, and year) Mar. 13 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 627

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Mingio Romano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Edvidia Romano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Antonio Farinaccio (Address)

15 Filed Nov 7-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1921, to Nov 6, 1921, that I last saw h[illegible] alive on Nov 5, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Child Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Mark L Steinbron M. D.

Nov 7 1921 (Address) 1058 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	Nov 8 1921
20 UNDERTAKER	ADDRESS
Wendell Lippold & Son	37 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58374

CERTIFICATE OF DEATH.

REGISTERED No. C 2079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Katherine Bauley

(Residence in Baltimore: No. 423 Rosedale Terrace St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): M

6-DATE OF BIRTH, Oct. (Month) 24 (Day), 1858 (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Springfield Mass.

PARENTS.

10-NAME OF FATHER: John Kelley

11-BIRTHPLACE OF FATHER (State or Country): Springfield Mass.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Litzinger

(Address) 423 Rosedale Terrace

15-

Filed ....., 191.... Registrar.

Robert F. Harrison,

Burial Permit Clerk.

V 7-1921

5806

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 23 1921, to Nov 5 1921, that I saw h.. alive on Nov 5 1921; and that death occurred, on the date stated above, at 10:30 Am.

The CAUSE OF DEATH* was as follows: Myocarditis Chronic

(Duration) 6-8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. Lloyd Johnson M. D.

....., 191... (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Nov. 8, 1921

20-UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Eight St

CAUSE OF DEATH must be plainly stated, and all items answered as far as practicable. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 58375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58375

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 E Eager ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella. R. Jenkins

(a) RESIDENCE NO. 1805 E. Eager. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of Jos. H. J. Jenkins

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Huttenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary O'Malley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Dr Warren V. Jenkins

(Address) 1805 E Eager St

15 Filed Nov 7 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to Nov. 5 1921.

that I last saw h alive on Nov. 5 1921.

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no. What test confirmed diagnosis? Exploring Incision

(Signed) E B Britton, M. D.

Nov 7. 1921 (Address) 1711 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov. 8 1921

20 UNDERTAKER: Henry Storck & Son — ADDRESS: 1391 E Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58376

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 E Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Keiner

(a) RESIDENCE. NO. 1918 E Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Keiner

6 DATE OF BIRTH (month, day, and year) May 25-56

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 069

(b) General nature of industry, business, or establishment in which employed (or employer) Plumber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Anna Keiner 1918 E Madison St

15 Filed Nov 7 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1917 to Nov 5 1921

that I last saw him alive on Nov 5 1921

and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) X yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Mayo M. D.

11/5 1921 (Address) 1638 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov 8 1921

20 UNDERTAKER Peter Riccards

ADDRESS 2046 Eastern Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58377

CERTIFICATE OF DEATH.

159

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 29 Gough Hospital ST., 8 WARD)

2-FULL NAME Arthur D. Pillsbury

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2901 Erdman a, St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1 (Year)

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer 034
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Amelia Dear

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hattie Evans

(Address) 2901 Erdman Ave

15- Robert F. Leitch, Deputy Clerk.

NOV 7 - 1921

Filed ....., 191.... Registrar.

Via B & O R.R. Co to Thomas E. Tyler.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) H. Bruce Gill M. D.
(Coroner.)

11-4 1921, (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Washington D.C. DATE OF BURIAL, Nov 7, 1921

20-UNDERTAKER William Cook ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58378

CERTIFICATE OF DEATH.

REGISTERED NO. 96 58378

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD) 64-0

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Getner

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed NOV 7-1921 Robert P. Harrison, Registrar

Daniel Perrit Clark,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from October 25. 1921. to November 3. 1921. that I last saw her alive on November 3, 1921. and that death occurred, on the date stated above, at 10:15 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/4/1921 Address [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov 8 - 1921
20 UNDERTAKER	ADDRESS
Wm C. Miller	2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58379

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58379

CERTIFICATE OF DEATH.

64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 219 Spalding Av ST.; 27 (WARD)

2-FULL NAME Sarah Lillies Norris

(a) RESIDENCE. No. 219 Spalding av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Late James F Norris

6 DATE OF BIRTH (month, day, and year) Jan. 1 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	10.	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Solomon Dowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane E Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Floyd Norris
(Address) Mardela Springs Md.

15 Filed Nov 7 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 5 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19 21, to Nov. 5 19 21, that I last saw her alive on Nov. 5 19 21, and that death occurred, on the date stated above, at 11:8 m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage with Hemiplegia right Side 3rd attack

(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) James S Ashhurst, M. D.

(Address) 1011 Park Heights av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 8 1921

20 UNDERTAKER ADDRESS

Harry H. Witzke 1511 W Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. (Not Statement of Occupa-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58380

1579

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 Clifton ave. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rakowsky

(a) RESIDENCE. No. 2506 Clifton ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66	Unknown			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER John Rakowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant J. Rakowsky
(Address) 2506 Clifton Ave

15 Filed 11-7-1921 Registrar Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1921, to Nov. 7, 1921, that I last saw him alive on Nov. 7, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valvular heart disease (duration) Years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronstead, M. D.

(Address) 615 Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	Nov 9 21
20 UNDERTAKER	ADDRESS
Harry A. Witzke	1531 Fenton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58381 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 58381

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No 748 George ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferland Branson

(a) RESIDENCE. No. 748 George ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany 19/1

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jno. Branson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lula Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Annie Branson

(Address) 748 George st

15 Filed NOV 8 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1921, to Nov. 7, 1921, that I last saw him alive on Nov. 6, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. Symp.

(Signed) Frank Livingood, M. D.

11/7, 1921 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ct	Nov. 8 1921
20 UNDERTAKER	**ADDRESS**
H. Fr. Brand & Son	108 N. Monto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificates.

See affidavit

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58382 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58382

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2102 E Balto St ST.: 6 WARD)

2-FULL NAME Beckie Katz

(a) RESIDENCE. No. 2102 E. Balto ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Brell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Maria Lipschitz
(Address) 200 E Fayette St

15 Filed NOV 8 - 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 20, to Nov 6, 19 21,
that I last saw h[illegible] alive on Nov 6, 19 21,
and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Uremic Nephritis.

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Nov 7. 1924 (Address) 1392 W Lanvale Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Herring Run Cemt	Nov. 8. 1924
20 UNDERTAKER	ADDRESS 1127 E Balto. St
Sol Levinson & Bro	

ERAL AFFIDAVIT

State of Maryland, Baltimore City to wit:

Be It Remembered, That on this 9th day of November

D. 19 21, before me, the subscriber, a Justice of the Peace of the said State in and for the City

aforesaid personally appeared

Hyman Katz residing at 2114 E. Pratt st

Baltimore City State of Maryland

made oath in due form of law that he is the son of Beckie

Katz who died on the 7th day of November

21 at Baltimore City - Md. that the age

the said Beckie Katz his mother was

fixed to in the death certificate as being

years of age - she further says that it is

rrect that her age at death was

years

ant's signature

Hyman Katz

Justice of the Peace.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58383

D 58383

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Jerome Smith

(a) RESIDENCE. No. 324 N. Gilmore St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7, 1979

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Melvin Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Toomey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mother (Gertrude Smith)
(Address) 324 N. Gilmore St

15 Filed NOV 8 1921 [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1921 to Nov. 6, 1921.

that I last saw him alive on Nov. 6, 1921.

and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 324 N. Gilmore St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms & Physical Signs.

(Signed) Geo. E. Wells. M. D.

, 19 (Address) Univ. Hospital Green & Lombard Sts Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 8 19
20 UNDERTAKER	ADDRESS
Sam'l Hemsley	1128 Bolton

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 58384

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3222 Cedar Ave 13 WARD)

2-FULL NAME Emma James

(a) RESIDENCE. NO. 3222 Cedar Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry James

6 DATE OF BIRTH (month, day, and year) Nov 2 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fronna Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frederick H Robinson (Address) 3222 Cedar Ave

15 Filed NOV 8 - 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1921, to Nov 6, 1921, that I last saw her alive on Nov 5, 1921, and that death occurred, on the date stated above, at 1140 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Inoperable

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo W Wood M. D.

11/7. 1921 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 8 1921

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58385

D 58385

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1562 Ridgely ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur W. Creamer

(a) RESIDENCE. NO. 1562 Ridgely ST., ..WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George L. Creamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen Sheppard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George L. Creamer
(Address) 1562 Ridgely St

15 NOV 8-1921 ROBERT A. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1921, to Nov. 8, 1921, that I last saw him alive on Nov 4, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Premature-
17 months)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 729 E. Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 9 1921
20 UNDERTAKER James Dignan & Son	ADDRESS 1005 S. Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58386

CERTIFICATE OF DEATH.

17 V

D 58386

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 N. Gilmor ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary V. McCullough.

(Residence in Baltimore: No. 1502 N. Gilmor St.; Life time yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Febry (Month) 28 (Day), 1874 (Year)

7-AGE, 47 yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired — 067
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe Dealership

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Jno H. Miller

11-BIRTHPLACE OF FATHER (State or Country). Caroline Co. Va.

12-MAIDEN NAME OF MOTHER Sarah J. Brooks.

13-BIRTHPLACE OF MOTHER (State or Country), Caroline Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. E. Dunker

(Address) 1540 N. Fulton

15- BOBERT J KRAUTER

Filed NOV 8 — 1921 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1921, to Nov 5 1921, that I saw her alive on Nov 4 1921, and that death occurred, on the date stated above, at 8:15 m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) yrs. 3 mos. ds.

(Signed) George E. Shannon M. D.

Nov. 5, 1921 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem — DATE OF BURIAL, Nov. 8, 1921

20-UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Bond St

CAUSE OF DEATH to be plainly written, so that it may be properly classified. All questions must be answered if possible. Every item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58387

CERTIFICATE OF DEATH.

D 58387

170

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 N. Paul ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Carroll Howard

(a) RESIDENCE. No. 939 N. Paul ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21st 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	Eighty 79	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: President Maryland Realty Co.

(b) General nature of industry, business, or establishment in which employed (or employer): Realtors

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jas Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Catherine M Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fredericksburg Va

14 Informant: David F. Howard
(Address) 939 N Paul St Balto Md

15 Filed NOV 8 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1921

17

I HEREBY CERTIFY, That I attended deceased from September 1st 1921, to November 5, 1921, that I last saw him alive on November 6, 1921, and that death occurred, on ~~the date stated above~~ Nov 6, at 5-45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis

(Signed) A. E. Atkinson, M. D.

19 (Address) 1010 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	11-9-1921
20 UNDERTAKER: Henry W. Jenkins Sons	ADDRESS: McCulloh & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 58388 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-089 D 58388

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 237 N Carlton ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses E Turner

(Residence in Baltimore: No. 237 N Carlton St.; yrs., 4 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, June (Month) 12 (Day), 1921 (Year)

7-AGE, yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt City

PARENTS.

10-NAME OF FATHER, Jerry Turner

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Susie Warren

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Turner

(Address) 237 N Carlton

15- ROBERT J KRAUTER

Filed NOV 8 - 1921 191.... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 6 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) James McPherson M. D. (Coroner.)

Nov 8, 1921. (Address) 700 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Nov 8, 1921
20-UNDERTAKER	ADDRESS
Brown & Frederick	Undertakers

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58389

D 58389

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 E Hoffman ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J Reese

(a) RESIDENCE. NO. 1225 E Hoffman ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dnt Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dnt Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Henchyman
(Address) 1225 E Hoffman St

15 Filed NOV 8 - 1921 BORIS J KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1921

17 I HEREBY CERTIFY, That I attended deceased from October 23, 1921, to Nov. 6, 1921, that I last saw h[illegible] alive on " " , 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (with Left Hemiplegia)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral paralysis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo A. Hoffman, M. D

Nov 7, 1921 (Address) 1221 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 9 1921
20 UNDERTAKER Robt J Turner	ADDRESS 14 N. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58390

CERTIFICATE OF DEATH.

170 ✓

REGISTERED NO. D 58390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 St. James ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Cook

(a) RESIDENCE. No. 1217 St. James ST.. 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Widor

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 140

(b) General nature of industry, business, or establishment in which employed (or employer): Labored

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): unknown Live in Balt 30 Years

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mrs Post (Address) 807 Sterling Av—

15 NOV 8 - 1921 ROBERT J. BRUTER Registrar

Burial Permit 01674

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 4 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1921, to Nov. 4, 1921, that I last saw h in alive on Nov. 3, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) — yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Uremic Coma

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

11/7/1921 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Novem 8 1921

20 UNDERTAKER: Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58391

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Gorowsky

(a) RESIDENCE NO. 1411 Nicholson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE OF: Alexander Gorowsky

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 33 (Years / Months / Days)

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland Russia

PARENTS

10 NAME OF FATHER: John Okrass

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Frances Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Alexander Gorowsky (Address) 1411 Archerfield St.

15 Filed NOV 8 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1921, to Nov 6th, 1921, that I last saw h[illegible] alive on Nov 6th, 1921, and that death occurred, on the date stated above, at 1.55 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure following Chronic valvular Disease (Aortic Insufficiency with Relative Mitral Insufficiency)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia Both Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 11/3/21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Adler Goldman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: Nov 9 1921

20 UNDERTAKER: William Strahlkowski

ADDRESS: Eastern Ave

mation should be carefully supplied. Exact statement of OCCUPA-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58391 — 42 D 58391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Ogrowsky (Regela Urzanowska)

(Residence in Baltimore: No. 1411 Nicholson St St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Not Known (Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, John Okrasa

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Frances Borowa

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Urzanowski

(Address) 1411 Nicholson St.

15- Filed NOV 8 - 1921, 191 ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 6th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3rd 191 , to Nov 6 191 , that I saw h er alive on Nov 6th 1921 , and that death occurred, on the date stated above, at 1.55 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia Right Middle Lung

(Duration) yrs. 7 mos. ds.

(Signed) A Stoller Southerner M. D.

Nov 8th, 1921. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov 9, 1921.

20-UNDERTAKER Wm Faehrmann — ADDRESS Eastern Ave

CAUSE OF DEATH must be given in full and plainly written. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58392

D 58392

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 S. 3rd St.; 26 Ward)

2-FULL NAME Margaret E. Ballentine

(a) RESIDENCE. No. Rossville Md St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Clarence E. Ballentine

6 DATE OF BIRTH (month, day, and year): Mar 15 84

7 AGE — Years: 37 — Months: 7 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Lemming

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Barbara —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Clarence E. Ballentine
(Address): Poplar Rd. Rossville

15 Filed NOV 8 - 1921, 19 — [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Nov 5, 1921, that I last saw h[illegible] alive on Nov 4 1921, and that death occurred, on the date stated above, at 7:10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis & Valvular heart disease [illegible] 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of not

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clarence E. Ballentine, M. D.

, 19 (Address) Rossville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Nov 8 1921

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had lived in Balto
life until 6 mos ago
when she went to
Rossville. Was in city
5 weeks when she
died.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58393

CERTIFICATE OF DEATH.

79 D 58393

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1933 Orleans St. 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Hasselbarth.

(Residence in Baltimore: No. 1933 Orleans St., St.; yrs. 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, Jan 1 (Month) (Day) 1878 (Year)

7-AGE, 43 yrs. 10 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Physicist
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Chas. Hasselbarth

11-BIRTHPLACE OF FATHER (State or Country), Ger.

12-MAIDEN NAME OF MOTHER Mary Siebert

13-BIRTHPLACE OF MOTHER (State or Country), Ger

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hasselbarth

(Address) 1933 Orleans

15-

Filed NOV 8 1921 191.....

ROBERT J. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Winslow M. D.
(Coroner.)

11-7-21, 191.., (Address) 19 E. Lex St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Schwark — DATE OF BURIAL, Nov 9, 1921

20-UNDERTAKER Philip Henry — ADDRESS 2016 Orleans

U. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Marie Pappas.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58394

CERTIFICATE OF DEATH.

15 | D 58394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 306 E. 27 ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Pappas

(a) RESIDENCE. No. 306 E. 27 ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. 1½ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6. 21

7 AGE — Years: — Months: — Days: 1½ — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Harry D. Pappas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Eulogia Pistola

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: Harry D. Pappas

(Address) 306 E. 27th St.

15 Filed . 19 ROBERT J. KRAUTER Registrar

NOV 8-1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8. 1921

17 I HEREBY CERTIFY, That I attended deceased from . 19 . to . 19 . that I last saw h[illegible] alive on Nov. 7 . 19 21, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Infant 6 Months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Marr M. D.

11-8-1921 (Address) 801 N. Eaton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem

DATE OF BURIAL: Nov 8 1921

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58395

CERTIFICATE OF DEATH.

70

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 76 WARD)

2-FULL NAME Mrs. Elizabeth Duvall

(a) RESIDENCE. No. Sinclair and Loneys Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles S. Duvall

6 DATE OF BIRTH (month, day, and year) June 30th 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Gottlieb Heckel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Rothkaupt

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Charles S. Duvall (Address) Sinclair Loneys Lane

15 NOV 8 - 1921 BOARD OF HEALTH Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to Nov. 6, 1921, that I last saw her alive on Nov. 6, 1921, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Otis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infected Leg.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Oct. 6, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Conte Jr, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Nov. 9th 1921
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58396

CERTIFICATE OF DEATH

113-091

D 58396

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Angelica C. Gamble

(a) RESIDENCE NO. Tallahassee, Fla ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Col. Robt. H. Gamble

6 DATE OF BIRTH (month, day, and year) May 12 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Dr. Alexander C. Robinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER M. Louisa Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Miss Louisa H. Robinson (Sister)
(Address)

15 Filed NOV 8-1921 ROBERT J. BRUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1921, to Nov 7, 1921,
that I last saw her alive on Nov 7, 1921,
and that death occurred, on the date stated above, at 11 00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

did not have Cancer

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exploratory Laparotomy for Cirrhosis of Liver (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 27, 1921

Was there an autopsy? No

What test confirmed diagnosis? Gastric findings

(Signed) E. L. Duncan, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 11/9/21

20 UNDERTAKER Henry W. Jenkins & Sons Co

ADDRESS Orchard & Mc Collick

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 58397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 58397

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 524 Columbia av ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludwig Musdeika

(Residence in Baltimore: No. 524 Columbia av — St.: 35 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: ..... Dont Know, 1.....
(Month) (Day) (Year)

7-AGE: 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 044

9-BIRTHPLACE, (State or Country): Lithuania

PARENTS.

10-NAME OF FATHER: Mathys Musdeika

11-BIRTHPLACE OF FATHER (State or Country): Lithuania

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or Country): Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Joseph Musdeika

(Address) 524 Columbia av

15- NOV 8 - 1921 Filed ..... 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov ..... 7 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

11-9....., 192.. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Nov. 10., 1921

20-UNDERTAKER John Grebliauckas

ADDRESS 1925 S. Broadway

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58398

CERTIFICATE OF DEATH.

D 58398

1-PLACE OF DEATH University Hospital

REGISTERED NO. 79

CITY OF BALTIMORE: (No. ... ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Zuburisky

(a) RESIDENCE. No. 110 N. Greene ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Frank Zuburisky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie (unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mat Unitus
(Address) 110 N. Greene

15 Filed NOV 8-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1921, to 11/7, 1921, that I last saw him alive on 11/7, 1921, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy.

(Signed) [illegible], M. D.

11/7, 1921 (Address) Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Nov 9 1921

20 UNDERTAKER John Grebliauckas ADDRESS 4255 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9VD 58399

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Peterson

(a) RESIDENCE. No. 740 Waescher St. ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DEceased

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Henry Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hagar Snipe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records,
(Address) New City Hospital.

NOV 8 - 1921 ROBERT J. FAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 5 19 21

17 I HEREBY CERTIFY, That I attended deceased from November 4, 19 21 to November 5, 19 21, that I last saw h. im alive on November 4, 19 21, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

11/5/19 21 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	Nov 8 1921
20 UNDERTAKER	ADDRESS
P. B. Gross	1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091 D 58400

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 211 N Pine St ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Gibbs

(Residence in Baltimore: No. 211 N Pine St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 29 (Day), 1921 (Year)

7-AGE, ...yrs. 4 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Herbert Gibbs

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER, May Fields

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Gibbs

(Address) 211 N Pine

15- Filed NOV 8 - 1921, 191.... ROBERT A KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 7th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ....yrs. 3 mos. 3 ds.

(Signed) H B Jamison (Coroner.) M. D.

11-7, 1921. (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 8, 1921

20-UNDERTAKER P G Gross

ADDRESS 1405 McElderry

N. B.—Correct certificate cannot be obtained unless CAUSE OF DEATH is given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Infant Marshall

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58401

D 58401

CERTIFICATE OF DEATH.

151 58401

D 58401

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3102 Barclay ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fortus Marshall 6 mos.

(Residence in Baltimore: No. 3102 Barclay St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Nov 7, 1921
(Month) (Day) (Year)

7-AGE, 1 yrs. about 2 mos. ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Robt L Marshall

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Emma Carter

13-BIRTHPLACE OF MOTHER (State or Country), Edmonville Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Robt L. Marshall

(Address) 3102 Barclay St

15- NOV 9 - 1921

Filed....., 191.... ROBERT J. BRAUNS Registrar

Serial Form 1 Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1921, to Nov. 7 1921, that I saw h— alive on Nov. 7 191..., and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Spasm
Duration 6 mos. Died
from exhaustion
with convulsions
(Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration)....yrs....mos....ds.

(Signed) H. V. Cox M. D.

Nov 8, 1921. (Address) 5 15 Mt Hope

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Nov 8, 1921

20-UNDERTAKER George W Holland

ADDRESS 1631 Ward St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

58402

D 58402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58420

D 58402

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 7008 North Payson ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Pannell

(Residence in Baltimore: No. 7008 North Payson St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Sing'l

6-DATE OF BIRTH, November 6, 1840
(Month) (Day) (Year)

7-AGE 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, W. J. Pannell

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Anna Fletcher

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles B Stupley

(Address) 7008 North Payson

15- NOV 9 - 1921 Filed ROBERT J. KRAUSE Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, as well as from personal knowledge, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Nov 7 1921 (Address) 2802 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Evergreen Cem Va — DATE OF BURIAL, Nov 8, 1921

20-UNDERTAKER William Cook — ADDRESS 502 Park Ave

via Br C & A Bolt, for Mrs Edward Towle.

N. B. EVERY ITEM must be answered and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

58403 HEALTH DEPARTMENT—CITY OF BALTIMORE 58403

D 58403 CERTIFICATE OF DEATH. 4N D 58403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Lanvaine Ave St., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Knull

(a) RESIDENCE NO. 404 Lanvaine Ave St. WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen J George D Knull

6 DATE OF BIRTH (month, day, and year): April 17-1845

7 AGE: Years 76 Months 6 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Honover Pa

PARENTS

10 NAME OF FATHER: Joseph Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hanover Pa

12 MAIDEN NAME OF MOTHER: Elizabeth Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hanover Pa

14 Informant: Miss Frances J Knull

(Address): 404 Lanvaine Ave

15 Filed NOV 9 - 1921 ROBERT I BEAUTER Registrar Deputy Registrar or Clerk

Knoff 1216 E Preston

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1921, to Nov 7, 1921, that I last saw her alive on Nov 7, 1921, and that death occurred, on the date stated above, at 1030 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert E Knapp M. D.

Nov 8, 1921 (Address) 1716 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Nov 10 1921

20 UNDERTAKER: J McCabe — ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 58404 58404

HEALTH DEPARTMENT—CITY OF BALTIMORE

58404

CERTIFICATE OF DEATH.

D 58404

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 Walbrook ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Louise Ziegler

(Residence in Baltimore: No. 2044 Walbrook Ave St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	widowed

6-DATE OF BIRTH, March 11, 1857 (Month) (Day) (Year)

7-AGE, 64 yrs. 7 mos. 26 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Thos High

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Anna L Fishpan

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Isabel Ensor

(Address) 2044 Walbrook Ave

15- Filed NOV 8 1921 191.... ROBERT J KRAUTER Burial Permit Registrar.

CAUSE OF DEATH In plain terms, as exact as may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1921, to Nov 7 1921, that I saw her alive on Nov 6 1921, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Gangrene of left ankle

(Duration) ....yrs. 11 mos. ....da.

(Signed) O. H. Dorsey M. D.

Nov 7, 1921. (Address) 1817 N. Sutton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 10, 1921.
20-UNDERTAKER Wm Cook	ADDRESS 507 E North ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 58405

HEALTH DEPARTMENT—CITY OF BALTIMORE

58405

137 D 58405

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francesca Scuto

(Residence in Baltimore: No. 534 S. Conway St.; 16 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 31 (Day), 1894 (Year)

7-AGE, 27 yrs. mos. da. If LESS than 1 day, hrs. or mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country). Cosenza (Italy)

PARENTS.

10-NAME OF FATHER, Joe Scuto

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Scuto

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Scuto

(Address) Franklin Square Hospital

15-

Filed NOV 9 1921 ROBERT J. KRANTZ Registrar.

Burial permit issued

CAUSE OF DEATH to be plainly stated, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Nov 7 1921, that I saw her alive on Nov 6 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. da.

(Signed) Luigi D. Stefano M. D.

Nov 7, 1921 (Address) 407 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 8 da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence 534 S. Conway St.

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross — DATE OF BURIAL, Nov 9, 1921.

20-UNDERTAKER, John P. Coby — ADDRESS 1318 E. Baltimore St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

58406
D 58406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 58406
91 D 58406

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Klehem

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hagerstown, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address): New City Hospital

15 FILED NOV 9 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19 1918 to November 8 1921 that I last saw her alive on November 7 1921 and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde M. Reed, M. D.

11/8/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Nov 9 1921
20 UNDERTAKER	ADDRESS
R. Sander Sons	1210 Park Ave

mation should be carefully supplied. Age should be stated EXACTLY. Particulars should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

58407 ✓ 58407

58407
D 58407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 58407
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2701 W. Westwood ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda E. Respess.

(a) RESIDENCE. No. 2701 W. Westwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter B. Respess

6 DATE OF BIRTH (month, day, and year) June 24. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	14	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tangier Va.

PARENTS

10 NAME OF FATHER Patrick H. Connorton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stanton Va.

12 MAIDEN NAME OF MOTHER Matilda J. Charnock.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tangier Va

14 Informant Walter B. Respess (Address) 2701 Westwood Ave.

15 Filed NOV 9 1921 ROBERT J. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1920, to Nov 7th, 1921, that I last saw h[er] alive on Nov 5th, 1921, and that death occurred, on the date stated above, at 7. 1. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

Laryngitis Tuberculous

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. G. Smith, M. D.

Nov 8, 21 (Address) 11 & 21 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 9th 1921

20 UNDERTAKER Mrs. Mrs John H. Deufel & Son ADDRESS 801 W. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58408

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST.: 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Morris

(a) RESIDENCE. No. 1532 Bate ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER James Coffey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Laughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr Ed Hagerty

(Address) 1606 Baker St

15 Filed NOV 9 - 1921 19 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1921, to Nov 8, 1921,

that I last saw her alive on Nov. 8, 1921,

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Auricular fibrillation.
Cardiac decompensation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Signs & Symptoms.

(Signed) John J. Coyle M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Southern Cem.	Nov. 11 1921
20 UNDERTAKER	ADDRESS
Martin Feeley & Sons	1827 N. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. State whether from Accident, Suicide or Homicide. INFORMATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58409

CERTIFICATE OF DEATH.

D 58409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 56 Ruckert ave ST.; Hamilton WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob F Kirkwood

(Residence in Baltimore: No. 56 Ruckert ave St.; 69 yrs., 11 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov 24, 1851. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
69 yrs. 11 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Fish Market

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John A Kirkwood

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Helgelberger

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pantheonia Kirkwood

(Address) 56 Ruckert ave

15- NOV 9 - 1921 Filed....., 191.... BOARD OF HEALTH Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to Nov 7 1921, that I saw h[illegible] alive on Nov 5 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) yrs. 3 mos. ds.

(Signed) R. C. Metcalf M. D.

Nov 9, 1921. (Address) 1903 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Nov 11, 1921.

20-UNDERTAKER	ADDRESS
W M Ponton	1238 N Broadway

CAUSE OF DEATH must be plainly stated, as data is very important. See instructions on back of certificate.

Spec. 6-9-[illegible] 1000 Bks.

D 58410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58410

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 Saunders St ST. 34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Hall

(a) RESIDENCE. NO. 408 Saunders St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susanne E Hall

6 DATE OF BIRTH (month, day, and year) Jan 20 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Erastus Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Willey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Harry Bradburn 408 Saunders St.

15 DATE RECEIVED NOV 9 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Nov 7, 1921, that I last saw him alive on Nov 6, 1921, and that death occurred, on the date stated above, at 6:55 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) G E Buxton, M. D.

11/7/1921 (Address) 301 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery Co.	Nov 9/21
20 UNDERTAKER	ADDRESS
Mrs J. E. Evans Sons	1425 E

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58411

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 24 W. Church St. St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Parren (C)

(Residence in Baltimore: No. 24 W. Church St. St.; 40 yrs., ------- mos. ------- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Widower.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE, ... 55 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 64

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, John Parren(C)

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER Mary A. Gross. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Parren(C) son.

(Address) 130 Winter St.

15- Filed NOV 9 - 1921 BOARD OF HEALTH Burial Permit Given Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Nov. 9th. 21, 191.. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn. St.	Nov. 9., 1921
20-UNDERTAKER	**ADDRESS**
E. L. Brown & Son. Co.	W. Montgomery St.

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58412

D 58412

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. German Aged Home ST.: Baltic Bayview 70 WARD)

2-FULL NAME Elizabeth Ramus

(a) RESIDENCE. No. German Aged Home ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant German Aged Home
(Address) Patapsco

15 NOV 9 - 1921 BUREAU OF VITAL STATISTICS Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22 1921, to Nov. 7th 1921,
that I last saw h[illegible] alive on Nov 6th. 1921,
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Uraemia).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Peter Ruff, M. D.

, 19 (Address) 1843 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — DATE OF BURIAL Nov 9 1921

20 UNDERTAKER Peter Nicolaus — ADDRESS 204 Easton

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 58413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 William St.; 24 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Clark

(Residence in Baltimore: No. 836 William St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 4, 1852
(Month) (Day) (Year)

7-AGE, 69 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, James A. Clark

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Kriel

(Address) 836 William

15-

FILED NOV 9 - 1921 DEPUTY REGISTRAR

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1921, to Nov 7 1921, that I saw her alive on Nov 7 1921; and that death occurred, on the date stated above, at 11.40 p m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis, Cardiac Insufficiency

(Duration) ....yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frances A. Carpenter M. D.

Nov. 7, 1921 (Address) 2106 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov. 10, 1921.

20-UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

(Jaskolaski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58414

CERTIFICATE OF DEATH.

104 D 58414

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 S Bond ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Jaskulski

(a) RESIDENCE NO. 833 S Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — dds

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lawrence Jaskulski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Catherine Perby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Lawrence Jaskulski

(Address) 833 S Bond St

NOV 9 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Nov 7, 1921, that I last saw h alive on Nov 7, 1921, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis & duodenitis

(duration) yrs. mos 2 4 ds.

CONTRIBUTORY (Secondary) Anthemia & Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay B Bullock, M. D.

19 21 (Address) 1623 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Cross — Nov 9 1921

UNDERTAKER John M Weber 1803 Bank St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

D 58415

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos Schultz

(a) RESIDENCE. No. 504 E. 24th ST., WARD. Nov. 7, 1921.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal.	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Schultz

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carrol Co Md.

PARENTS

10 NAME OF FATHER Lester Shultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co

12 MAIDEN NAME OF MOTHER Carrol Co.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Amos R Schultz

(Address) Hampstead Md

15 Filed NOV 9 - 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7. 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1921 19 , to Nov. 7, 19 21.

that I last saw him alive on Nov. 7 , 19 21.

and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophied Insufficiency

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. methods

(Signed) Nestor de Cardenas, M. D.

, 19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monktor. Md.	Nov 10 1921
20 UNDERTAKER Wm J Fleckner Sons	ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58416 **CERTIFICATE OF DEATH.** 104 D 58416

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Mersey Hospital St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Lankford,

(Residence in Baltimore: No. 1030 S. Sharp St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: Dr E. Lankford

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Margaret McInnis

13-BIRTHPLACE OF MOTHER (State or Country): N York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr Lankford

(Address) 1030 S. Sharp St

Filed NOV 9 - 1921, 191.... ROBERT J KRAUTH Clerk

Burial Permit No. 18952

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Coroner or autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Embolus

..... (Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) W K Gordon M. D. (Coroner)

11-7, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....dg. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, Nov 1921

20-UNDERTAKER — ADDRESS

Commissioner of Health, BALTIMORE

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Eva M. Holt

D 58417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58417

CERTIFICATE OF DEATH.

X 74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Eva Mae Holt

(a) RESIDENCE. NO. Mount Olive N. Ca. ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE 15 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Jeptha A. Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Minnie Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: JOHNS HOPKINS HOSPITAL. Records.
(Address)

15 Filed NOV 9 - 1921, 19 ROBERT A KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9- 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 - 1921, to Nov 9 1921,
that I last saw her alive on Nov 9- 1921,
and that death occurred, on the date stated above, at 12.20 a- m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Nov 9 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Holman M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salisbury N. C.

DATE OF BURIAL: Nov-9 1921

20 UNDERTAKER: Joseph Abrens

ADDRESS: 221 N. Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58418 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58418

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH St. Vincents Infant Asylum REGISTERED NO.

CITY OF BALTIMORE: (No. 1401 Division ST.: 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Francis Isaac

(a) RESIDENCE: NO. 1401 Division ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Veronica Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant St Vincents (Address) 1401 Division St

15 Filed NOV 3 1921 19 J E Kehoe Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 7, 1921, that I last saw him alive on Nov. 7 1921, and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Holcombe M. D.

Nov 7 1921 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Nova — DATE OF BURIAL 1921

20 UNDERTAKER: N Fahey & Sons — ADDRESS 1827 W North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58419

CERTIFICATE OF DEATH.

X104 D 58419

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE: (No. 1401 Division St. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Shipley

(a) RESIDENCE. NO. 1401 Division ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1920

7 AGE: Years | Months: 10 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Maryland

PARENTS

10 NAME OF FATHER Robert Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Main

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St Vincents (Address) 1401 Division

15 Filed NOV 9 - 1921 Registrar J E Helms

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 7, 1921, that I last saw her alive on Nov 7, 1921, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Heuisler, M. D.

Nov 8, 1921 (Address) 1500 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Nov 9 1921

20 UNDERTAKER: M Fahey & Sons — ADDRESS: 1829 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58420

CERTIFICATE OF DEATH.

170 D 58420

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 E 28 St ST. 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M. L. Becker

(a) RESIDENCE NO. 518 E 28 St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower of Sophia Becker

6 DATE OF BIRTH (month, day, and year): July 22 1845

7 AGE: Years 76 Months 3 Days ..... If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Philip Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Supon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Sophia Becker (Address) 518 E 28 St

15 Filed ..... 19 ..... Registrar

Murphy Undertaking Co 25 E Baltimore

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1921, to Nov 7 1921, that I last saw h[e] alive on Nov 7 1921, and that death occurred, on the date stated above, at 9:40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. ? mos ..... ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Guy Thomas Oliver M. D.

11/8/1921 (Address) 4016 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 11/9/21

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

IMPORTANT should be carefully supervised so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58421

CERTIFICATE OF DEATH.

120

D 58421

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3685 Ash ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Slingerland

(a) RESIDENCE NO. 3685 Ash ST., ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, Divorced, (write the word) Widowed

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter Slingerland

6 DATE OF BIRTH (month, day, and year) Aug 1st 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ohio Saphel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Jos. Harris

(Address) 3685 Ash

15 Filed NOV 9 - 1921 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Nov. 8, 1921, that I last saw h[illegible] alive on Nov. 8 1921 and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 84 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ... yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Typical signs

(Signed) C Tompkins M. D.

11-9, 1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Maryland	11/10/21.
20 UNDERTAKER William Cook	ADDRESS 501 E 20th

information should be correctly supplied. Exact statement of OCCUPATION so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 58422

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2922 St Paul ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henry Truitt

(a) RESIDENCE NO. 2922 St Paul ST. St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Dead yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Widowed Rebecca A Truitt

6 DATE OF BIRTH (month, day, and year): April 15/1833

7 AGE: Years 88 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Capt Ord

(b) General nature of industry, business, or establishment in which employed (or employer): Steamboat

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Dover Delaware

PARENTS

10 NAME OF FATHER: Elisha Truitt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dover Delaware

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dover Delaware

14 Informant: Mrs A. E. Faidley

(Address) 2922 St. Paul St

15 NOV 9 - 1921 J E Nelson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 31 1921, to Nov 8 1921.

that I last saw h alive on Nov 7 1921.

and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Infec. Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Long Station

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Series Buck M. D.

Nov 8 1921 (Address) 2544 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 11 1921
20 UNDERTAKER: William Cook Sons & Nolte	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 58423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54 D 58423

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Cohen

(a) RESIDENCE. No. 2124 E. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (~~or WIFE of~~) Esther Cohen

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dresser 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Max Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sarah Cohen

Address 2124 E Lombard St

15 Filed NOV 9 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/21 19

17 I HEREBY CERTIFY, That I attended deceased from 8/7/21, 19, to 11/8/21, 19, that I last saw him alive on 11/8/21, 19, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Primary Aplastic Anemia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Ezzinburg, M. D.

11/8/1919 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hebrew Ass'n

DATE OF BURIAL: Nov. 9. 1921

20 UNDERTAKER: Sol Levinson Bro

ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58424

CERTIFICATE OF DEATH.

REGISTERED NO. 560

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 S. Fourteenth St.: 25 Ward)

2-FULL NAME David De Ment

(a) RESIDENCE. No. 304 S. Fourteenth St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Blanche A. De Ment.

6 DATE OF BIRTH (month, day, and year) Sept 5 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER Martin De Ment.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER Roda Stury

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio.

14 Informant: Blanche A. De Ment.
(Address) 304 S Fourteenth St.

15 Filed NOV. 9 1921 [illegible] Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1921

17

I HEREBY CERTIFY, That I attended deceased from 11/6/21 . 19 , to 11/6/21 . 19 , that I last saw him alive on 11/6/21 . 19 , and that death occurred, on the date stated above, at 1.06 P. m.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. O'Donnell M. D.

19 (Address) 633-5-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Nov. 10 1921
20 UNDERTAKER: Lilly & Son	ADDRESS: 403 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Blks.

D 58425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9V D 58425

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 Rosekemp ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Shaw

(a) RESIDENCE NO. 40 Rosekemp ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND OF~~ or) WIFE of Henry Shaw

6 DATE OF BIRTH (month, day, and year) May 10th 1846

7 AGE	Years	Months	Days	11 LESS than 1 day, hrs. or .... min.
	75	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 000

(b) General nature of industry, business, or establishment in which employed (or employer) Same

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Jonathan Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Greenwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Miss Mary Shaw

(Address) 40 Rosekemp ave ~~USUAL PLACE OF RESIDENCE~~

15 NOV 9 1921 Filed ~~Burial Permit Issued~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6 , 1921 , to Nov. 6 , 1921 .

that I last saw her alive on Nov. 6 , 1921 ,

and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

(RA) Lobar Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (RA) (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Greene, M. D.

11/7, 1921 (Address) Hamilton Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 10th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 58426 — 170 D 58426

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1915 W. Lafayette Av ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Johanna Wigner

(Residence in Baltimore: No. 1915 W. Lafayette Av St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female — 4-COLOR OR RACE: White — 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed

6-DATE OF BIRTH: Dec (Month) 15 (Day), 1835 (Year)

7-AGE: 85 yrs. 10 mos. 24 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Wash. D.C.

PARENTS

10-NAME OF FATHER: Frederick Kupfer

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Cordia Rudolph

13-BIRTHPLACE OF MOTHER (State or country): Balto. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. Wegner

(Address) 1915 W. Lafayette Ave

15- BURNEY A. KRAUTH

Filed NOV 9 - 1921 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 8 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 3, 1921, to, Nov. 8 1921, that I saw her alive on November 7 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

unknown (Duration) — yrs — mos. — ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis

unknown (Duration) yrs mos. ds.

(Signed) Chas. Gelb M. D.

Nov. 9th 1921 [Address] 1111 W. Baltimore St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Nov 10 1921

20-UNDERTAKER: N. S. Marshall — ADDRESS: 2539 Fall Rd

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58427 ✓ 8/D 58427

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 752 Redwood ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Young

(a) RESIDENCE. NO. 752 Redwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Young

6 DATE OF BIRTH (month, day, and year) Jan 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 186

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Michaels Md Talbot Co

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Omar Butler (Address) 239 N Rose St

15 Filed NOV 9 1921 19.. ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6th 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/4 . 1921 . to 11/6 . 1921 . that I last saw h in alive on 11/5 . 1921 . and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Gustav Feldmann, M. D

. 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Nov 9 1921

20 UNDERTAKER P L Gott ADDRESS 1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58428

D 58428

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Arlington Ave. WARD) 18

2-FULL NAME James Edward Smith

(a) RESIDENCE. No. 503 N. Arlington Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of [redacted] Mary Elizabeth Smith

6 DATE OF BIRTH (month, day, and year) Dec. 4. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police Sargent 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md U.S.A.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Scally

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Dr. R C A Johns) (Address) 3014 St Paul St.

15 Filed NOV 9 - 1921 . 19 ROBERT J. KRAETZER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25th, 1921, to Nov. 7th, 1921, that I last saw h him alive on Nov. 7th, 1921, and that death occurred, on the date stated above, at 10:45 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C Johns, M. D.

11/8, 1921 (Address) 3014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/10 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—R. P. Co.—1000 Bks.

D 58429

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

120 D 58429

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 105 S. Carlton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Reich

(a) RESIDENCE. NO. 105 S Carlton ST. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. X mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work D.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Jno Carthwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Reich
(Address) 401 S. Payson st

15 Filed NOV 8 - 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/21 19

17 I HEREBY CERTIFY, That I attended deceased from 11/3/ 19 21, to 11/8/ 19 21,

that I last saw h alive on 11/8/21 19

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Chr Diff nephritis
Uremia Pneumg.

(duration) Hrly yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) B J Sing, M. D.

11/9/1921 (Address) 915 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 10 1921
20 UNDERTAKER	ADDRESS 1008
Geo J Smith	Fayette [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 58430 PLACE OF DEATH

74 ✓

REGISTERED No. D 58430

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 1610 John St. St. 14 WARD)

2-FULL NAME Henry Murray Brooks

(Residence in Baltimore: No. 1610 John St St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (If write the word): Married

6-DATE OF BIRTH: May 3 (Month) (Day), 1868 (Year)

7-AGE: 53 yrs. 5 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Spices &c

566

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Joshua Brooks

11-BIRTHPLACE OF FATHER (State or country): Catonsville Md

12-MAIDEN NAME OF MOTHER: Columbia Giesking

13-BIRTHPLACE OF MOTHER (State or country): Westminster Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Bessie W. Brooks
(Address) 1610 John St

15-
Filed NOV 9 - 1921
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to Nov. 8, 1921, that I saw him alive on Nov. 8, 1921, and that death occurred, on the date stated above, at 11:30 a m.
The CAUSE OF DEATH* was as follows:

TUMOR CEREBRI.

(Duration) about 2 yrs. mos. ds

Contributory (SECONDARY) Mastoiditis

(Duration) yrs. 6-8 mos. ds.

(Signed) Carroll Lockard M. D.
Nov. 9, 1921 (Address) 45 Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount

DATE OF BURIAL: Nov. 11, 1921

20-UNDERTAKER: George J. Smith

ADDRESS: 5000 W Fayette St

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 58431
1 PLACE OF DEATH

CERTIFICATE OF DEATH

79 D 58431
REGISTERED NO. C

CITY OF BALTIMORE (No 1441 Main St Mt Winans ST. 26 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Riser

(Residence in Baltimore: No. 1441 Main St St.: 10 yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: October 14, 1911 (Month) (Day) (Year)

7 AGE: 10 yrs. 1 mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles H. Riser

11 BIRTHPLACE OF FATHER (State or country): Martinsburg W Va

12 MAIDEN NAME OF MOTHER: Maud M. Ellers

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. Riser

(Address) 1441 Main St.

15 Filed NOV 9 - 1921 BOARD OF HEALTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 8, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1921, to Nov 8 1921, that I saw him alive on Nov 8, 1921, and that death occurred, on the date stated above, at 5:20 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Congestion of Lungs

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Cardiac dropsy

(Duration) yrs. mos. ds.

(Signed) Wm. B. Hall M. D.

11-8-, 1921. (Address) Halethorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Nov 11, 1921

20 UNDERTAKER: George J. Smith — ADDRESS: 1000 W Fayette St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58432

CERTIFICATE OF DEATH.

167 D 58432

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia M Stark

(Residence in Baltimore: No. 1431 Frederick ave

60

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, April 7, 1859
(Month) (Day) (Year)

7-AGE, 62 yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Charles Lapp

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emilie Von Lonberg

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Charles E Stark

(Address)..1631 Frederick ave

NOV 9 - 1921 ROBERT J KRAUTER

Filed....., 191... Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Burns over greater part of body, face & clothes
(b) Catching fire from Heating Stove,
Accident
(Duration)..... yrs..... mos. 2 ds.

CONTRIBUTORY (Secondary)
(Duration)..... yrs..... mos..... ds.

(Signed) James M Fenton M. D.
(Coroner.)

Nov 8, 1921. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos. 2 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?..... 1631 Frederick ave

Former or usual residence 1631 Frederick ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Nov 10, 1921
20-UNDERTAKER	ADDRESS
John Henry & Co	2008 Eutaw

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 58433

D 58433

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 S. Curley St. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard R. Celly

(a) RESIDENCE. No. 529 S. Curley St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred – yrs. 8 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of –
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	–	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John M. Celly

11 BIRTHPLACE OF FATHER (city or town) Italy.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Anderson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.

14 Informant Anna Anderson
(Address) 529 S. Curley St.

NOV 9 - 1921 BOWEN & KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1921, to Nov 8, 1921, that I last saw h.. alive on Nov 7 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) G. Kent Fraley M. D.

, 19 (Address) 2458 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Nov. 10 1921
20 UNDERTAKER Zirkler + Zirkler	ADDRESS 1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 58434

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 70 WARD)

2-FULL NAME Geo. Vannemvotech

(a) RESIDENCE NO. 136 Calverton Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie C. Vannemvotech

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 213

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Vannemvotech

(Address) 136 Calverton Rd

15 NOV 9 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8-1921

17 I HEREBY CERTIFY, That I attended deceased from 10-30, 1921, to 11-8, 1921, that I last saw him alive on 11-8, 1921 and that death occurred, on the date stated above, at 5.35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lues

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov. 11 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schwab	2101 Eutaw Pl.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 58435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58435

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at 29 REGISTERED No. C

CITY OF BALTIMORE (No. Franklin Square Hospital 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Swann

(Residence in Baltimore: No. 2235 W Balto St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	widow

6-DATE OF BIRTH, Oct (Month) 29 (Day), 1849 (Year)

7-AGE, 72 yrs. 10 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)..... self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Keyser

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Craven Swann

(Address) 2235 W Balto St

15- Filed ....., 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

NOV 9 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute delation of heart (Duration) sudden yrs. mos. ds.

(Signed) James McKeever M. D. (Coroner.)

Nov 9, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH; in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet — DATE OF BURIAL, Nov 10, 1921

20-UNDERTAKER John J Fields — ADDRESS 1200 N Fremont

I.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Floantine)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58436

D 58436

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of America Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 418 W Lexington ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Eliz Florentine

(a) RESIDENCE. No 619 S. Paca ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emil Florentine

6 DATE OF BIRTH (month, day, and year) 23rd - Sep. 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - md

PARENTS

10 NAME OF FATHER J. H. Lowe

11 BIRTHPLACE OF FATHER (city or town) Talbot Co (State or country) md

12 MAIDEN NAME OF MOTHER Eida Parker

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md

14 Informant Fasure - J. H. Lowe
(Address) 619 S. Paca St.

15 Filed NOV 9 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1921, to Nov. 8, 1921, that I last saw her alive on Nov. 8, 1921, and that death occurred, on the date stated above, at 9. p. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Some place —

Did an operation precede death? Yes Date of Nov. 4-21

Was there an autopsy? No

What test confirmed diagnosis? By Auscultation & a Still born Baby

(Signed) J. L. Fayaweather, M. D.

. 19 (Address) 418 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 12 1921
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation forceps delivery still born baby.

Spec. 6-19 H. P. Co.—1000 Blks.

150805

D 58437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58437

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. St.: 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Connolly

(a) RESIDENCE. No. 926 Harford Ave. St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christopher Connolly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Mud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed Robert P. Harrison, Registrar

9 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19th, 1921, to Nov 6th, 1921, that I last saw h[illegible] alive on Nov. 6th, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Metastasis Pyelonephritis

(duration) yrs. 5 mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia Puerperal Causes Code 2 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edwin Towles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Nov	10 1921

20 UNDERTAKER H. C. Wiedefeld & Co Greenmt Ave ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58438

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 128 S. Broadway ST.: 3 WARD)

2-FULL NAME Frances A. Propf

(a) RESIDENCE. No 128 S. Broadway ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Harry E. Propf

6 DATE OF BIRTH (month, day, and year) Oct. 28-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. W. Bean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Jennie Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Harry E. Propf
(Address) 128 S. Broadway

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

9-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1 1920, to Nov. 7 1921, that I last saw her alive on Nov. 6 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Embolism

(duration) yrs. ... mos. 4 days

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. H. Bigelow M. D.

19 (Address) 6 W. Mt. Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Nov. 10 1921

20 UNDERTAKER ADDRESS

Wm. C. Black 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58439

CERTIFICATE OF DEATH.

91 D 58439

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Marshall. ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. Franz.

(a) RESIDENCE. NO. 1404 Marshall. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If ~~married, widowed or divorced~~ HUSBAND of ~~(or WIFE)~~ Mary Franz.

6 DATE OF BIRTH (month, day, and year) June 29 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	4	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John. Franz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary Franz. (Wife) (Address) 1404 Marshall St

15 Filed Robert P. Harrison, Registrar

9 Jan 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 4/21 19 , to Nov 6/21 19 , that I last saw him alive on Nov 6/21 19 , and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jas H O'Donnell, M. D.

. 19 (Address) 1072 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co.	11-10 1921
20 UNDERTAKER	ADDRESS
E. B. Hale	415 E Mt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58440 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58440

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1702 N. Caroline (St.) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry C. Day

(a) RESIDENCE. No. 1702 N. Caroline St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Nellie Day

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Laces

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Eliz J. Peacock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Nellie Day (Address) 1702 N Caroline St.

15 Filed 19 Robert P. Harrison, Registrar

9-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 8. 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 19 19, to November 8th 19 21, that I last saw h in alive on November 8th 19 21, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Carbon Monoxide Gas

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos H. A. Mayer, M. D.

11/9, 19 21 (Address) 1031 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	11/11 1921

20 UNDERTAKER Chas F. Evans & Son ADDRESS Mount Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

D 58441

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1529 W. Lexington ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew C. Moriarty

(a) RESIDENCE. NO. 1529 W. Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Abt 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie R. Moriarty

6 DATE OF BIRTH (month, day, and year) April 6" 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dublin, Ireland

PARENTS

10 NAME OF FATHER Matthew Moriarty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Thunder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Annie C. Moriarty 1529 W. Lexington St.

15 Filed NOV 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8" 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 14, 1921, to Nov 8, 1921, that I last saw him alive on Nov 7, 1921, and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 or 4 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) M Brennan Hood, M. D.

Nov 9, 1921 (Address) 626 N. Johnson St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Nov. 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Bond St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES must be made in ink
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D 58442

HEALTH DEPARTMENT—CITY OF BALTIMORE

169 D 58442

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Fond Light st. Wharf ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Washington C
403 Dover

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 37 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Oyster Co

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Frank Washington

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Bert Washington

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Washington

(Address) 403 Dover

15-

Filed NOV 10 1921 ROBERT J. KRAUTH Registrar

Burial p. m. Registered

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
a.c. Exhaustion Delirium
Tremens (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Stahl M. D.
(Coroner.)
Nov. 10, 1921 (Address) 1037 Dover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). Resided in Baltimore
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn
DATE OF BURIAL, Nov 11, 1921

20-UNDERTAKER Daniel Easton
ADDRESS 916 Pa Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Perelz

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58443

CERTIFICATE OF DEATH.

79 D 58443

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Peretz

(a) RESIDENCE. NO. 1515 E. Pratt ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? Never yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Colman Peretz

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Leurs (Address) 1411 E. Baltimore St.

15 Filed NOV 10 1921 19 ROBERT I. FEASTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/21 19

17 I HEREBY CERTIFY, That I attended deceased from 11/2/21, 19, to 11/9/21, 19, that I last saw her alive on 11/9/21, 19, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Zinberg, M. D.

4/9, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rockingham Rd

DATE OF BURIAL 11/10/21 19

20 UNDERTAKER Jack Leurs

ADDRESS 1411 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58444

CERTIFICATE OF DEATH.

64 D 58444

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 E. Pratt street ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bessie Seidman

(Residence in Baltimore: No. 1509 E. Pratt street)

1 (Yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: Unknown (Month) (Day), 1836 (Year)

7-AGE: 85 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore St.

15-

Filed NOV 10 1921 191.. ROBERT A. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Sayer M. D.
(Coroner.)

Nov 8, 1921. (Address) 1500 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Rehrer McCarmel — DATE OF BURIAL, Nov 10, 1921

20-UNDERTAKER: Jack Lewis — ADDRESS 1411 E. Baltimore St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S entry of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58445

CERTIFICATE OF DEATH.

175-001 D 58445

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Moore

(Residence in Baltimore: No. 1008 Warden St. yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widd

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE. 63 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Chamoffice
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE. (State or Country), Boston

PARENTS.

10-NAME OF FATHER, James Curran

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Burns

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Peter Rummell

(Address) 1008 Warden

15-

FILED NOV 10 1921 ROBERT J. BRAUER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) and held Nov 11 thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion brain - with Hemorrhage
Back of head - Caused by injuries
Received by automobile - Driven by
another (Duration) mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Riley M. D.
(Coroner)

Nov, 1921 (Address) 1603 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL, Nov 11, 1921

20-UNDERTAKER Henry Hoeck Son — ADDRESS 1321 E Lex

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58446

CERTIFICATE OF DEATH.

K 37 ✓

D 58446

1-PLACE OF DEATH US PHS Hosp. #56

CITY OF BALTIMORE: (No. Baltimore Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willaim Hawkins

(a) RESIDENCE NO. US PHS Hosp. #56 Balto, Md. ST.,--- WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	39 ,yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 886

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrock Registrar

(Address) US. PHS Hosp. # 56 Balto, Md.

15 Date NOV 10 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1921 to Nov. 8, 1921.

that I last saw him alive on Nov 8, 1921.

and that death occurred, on the date stated above, at 8'45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary adv. & active.

Syphilis, general.

--- (duration)-- yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis chronic interstitial

-- (duration) yrs.--- mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam. & Clinic report

(Signed) Thomas B. Payne M. D.

Senior Surgeon(R)

11/8, 1921 (Address) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemtry

DATE OF BURIAL 11.8.1 1921

20 UNDERTAKER Jos Guinor & Bro

ADDRESS 1127 E. Balto St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58447

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Rob't Garrett Hosp for Children REGISTERED NO.....

CITY OF BALTIMORE: (NO. 27 N Carey ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Baumgarh

(a) RESIDENCE. NO. 1519 Jackson ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12, 1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Joseph F. Baumgarh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma M Poole

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Joseph F. Baumgarh
(Address) 1519 Jackson St

BURIAL PERMIT

15 Filed NOV 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1921, to Nov 8, 1921, that I last saw h[illegible] alive on Nov 8, 1921, and that death occurred, on the date stated above, at 12-0 m.

The CAUSE OF DEATH* was as follows:

Marasmus Pemphigus

(durntion) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

*(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted
If not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Exam

(Signed) Jerome Cluff, M. D.

11/9, 19 / (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 9 1921
20 UNDERTAKER Chenowith Son	ADDRESS Chestnut St

mation should be carefully supplied. Age should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58448

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3519 Gough ST., 76 WARD)

2-FULL NAME Emma V. Harris

(a) RESIDENCE NO. 3519 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Harris

6 DATE OF BIRTH (month, day, and year) June 22-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER Charles Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Dentsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Mrs Ella Brown
(Address) 3519 Gough St

15 Filed NOV 10 1921 J.E.Wilm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 19 19, to Nov 8th, 19 21,

that I last saw h alive on Nov 7th, 19 21

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. 11 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H. E. Delworth M. D.

11/9, 1921 (Address) 1348 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	11-11-1921
20 UNDERTAKER J. G. Moran	ADDRESS 3100 E. Baltimore

N. B. ... should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Infant Sapp.

D 58449

HEALTH DEPARTMENT--CITY OF BALTIMORE

151 ✓ D 58449

CERTIFICATE OF DEATH

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 104 N. Schroeder St 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Sapp (If not known, give nearest relative)

(Residence in Baltimore: No. 104 N. Schroeder St St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH 11 (Month) 8 (Day), 1921 (Year)

7-AGE — yrs. — mos. — ds. If LESS than 1 day 24 hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ooW
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) City

PARENTS

10-NAME OF FATHER Harry Sapp

11-BIRTHPLACE OF FATHER (State or country) South Carolina

12-MAIDEN NAME OF MOTHER Mary Perdue

13-BIRTHPLACE OF MOTHER (State or country) South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Sapp

(Address) 104 N. Schroeder St

15 NOV 10 1921 ROBERT J KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 11 (Month) 9 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1921, to Nov 9th 1921, that I saw h.. alive on Nov 8th 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lack of Vitality

21 hours

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Nov 9, 1921 (Address) ..... E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Peters Cem

DATE OF BURIAL Nov 10, 1921

20-UNDERTAKER Brown & Englehardt

ADDRESS 114 N. Schroeder St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. —6-9-19—H. P. Co.—1000 Bks.

D 58450 HEALTH DEPARTMENT—CITY OF BALTIMORE 172 D 58450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary B. Bush

(a) RESIDENCE. No. 415 So Fulmor ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE: Years 72 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Marquam

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Atwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Harry M. Bush. (Address) 415 S. Fulmor

15 Filed NOV 10 1921 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1921, to Nov 8, 1921, that I last saw her alive on Nov 8, 1921, and that death occurred, on the date stated above, at 3:35 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis
Gangrene

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Dementia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) John J. Erwin M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Nov 10 1921

20 UNDERTAKER: Harry H. Weitzfa — ADDRESS: 1531 W. Fayette.

information should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58451

D 58451

CERTIFICATE OF DEATH.

1320

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret T. Wolf

(a) RESIDENCE. NO. Forney P O Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Henry Wolf

6 DATE OF BIRTH (month, day, and year) October 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Heath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. Records
(Address)

15 Filed . 19 NOV 1 1921 H. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6 , 1921 , to 11-8 , 1921 ,

that I last saw h er alive on 11-8 , 1921 ,

and that death occurred, on the date stated above, at 3.10 a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy - Uremia - (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? Forney Station

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Cooles Andrus , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Nov 11 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

mation should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58452

CERTIFICATE OF DEATH.

D 58452

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 Ausgusta St. 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) 12 15 a m

2-FULL NAME Sarah R. Boone

(a) RESIDENCE. No. 702 Ausgusta St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of William H. Boone

6 DATE OF BIRTH (month, day, and year) Jan 8. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James Young

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Parks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Ella R Boone (Address) 702 Ausgusta St

15 Filed NOV 10 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20 1921, to Nov. 9 1921, that I last saw her alive on Nov. 8 1921, and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchites (duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. E. Bruntorb M. D.

. 19 (Address) 1508 E. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov 11 1921
20 UNDERTAKER	ADDRESS
John B. Spence	1325 N. Caroline St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Kerstenhagen

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58453

CERTIFICATE OF DEATH.

151 D 58453

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3400 E Lombard ST.: 26 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kerstenhagen

(Residence in Baltimore: No. 3400 E Lombard St St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Sgle

6-DATE OF BIRTH, May 6, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Louis Kerstenhagen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Dora Silman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kerstenhagen

(Address) 3400 E Lombard

15- NOV 1 0 1921

Filed ....., 191.. Gilhelm Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to 2 death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Lyon Most Co M. D.
Coroner.

May 11, 1921 (Address) 1509 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon	May 12, 1921

20-UNDERTAKER	ADDRESS
Randall Appleton	37 Penn St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58454

CERTIFICATE OF DEATH.

40 D 58454

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Biedler & Sellman ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Crafts Griffith

(Residence in Baltimore: No. 1010 Mad. Ave St.; 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 27 (Day), 1864 (Year)

7-AGE, 57 yrs. 5 mos. 13 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk B. & O. R. R.
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Rockville Md

PARENTS.

10-NAME OF FATHER, Philemon Griffith

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. H. Norman

(Address) Baltimore & Light St.

15- NOV 13 1921

Filed ....., 191.... J. H. Wilson Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 7 1912, to Nov 10 1921, that I saw him alive on Nov 9 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno A Luetscher M. D.

Nov. 10, 1921. (Address) 1025 Mad. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Rockville Md. DATE OF BURIAL, Nov. 14, 1921

20-UNDERTAKER, W. J. Tschan ADDRESS North Ave

N. B.—ENTRIES MUST be made in this record at the time the certificate is filed. Exact address of OCCUPATION must be given. CAUSE OF DEATH must be properly classified. Exact address of OCCUPATION must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact address of OCCUPATION must be given. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58455 ✓ 120 D 58455

CERTIFICATE OF DEATH.

REGISTERED No. C

D 58455

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1635 E Fayette St. (WARD) 6

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Lebovitz

(Residence in Baltimore: No.) 1635 E Fayette

At 25 (St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1 (Year)

7-AGE, 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country) Russia

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... (Address) 1411 E Baltimore St

Filed NOV 10 1921 191... ROBERT I KRAUTER Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Inter Nephritis

(Duration) ... yrs. 4 mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) ... yrs. mos. 1 ds.

(Signed) J. E. Blades M. D. (Coroner)

1921 (Address) 143 E Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, 11-10-21

20-UNDERTAKER Jack Krauter — ADDRESS 1411 E Balto

N.B.—Every item of information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58456

CERTIFICATE OF DEATH.

1920

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Clinton Avenue ST.: 17 WARD)

2-FULL NAME Mary Ellen Scott

(a) RESIDENCE. No. 606 Clinton Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edgar Scott

6 DATE OF BIRTH (month, day, and year) Unknown 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William L. Campbell

11 BIRTHPLACE OF FATHER (city or town) Manchester
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Carroll

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Florence Scott
(Address) 606 Clinton Ave.

15 Filed NOV 10 1921 ROBERT J. BRAUNE Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Nov 8, 1921, that I last saw h[illegible] alive on Nov. 7, 1921, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Ex.

(Signed) E B Britton, M. D.

11/9, 1921 (Address) 1711 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	11/11/1921
20 UNDERTAKER	ADDRESS
J. B. Cook	1003 E. Balto. St.

All information should be carefully supplied. AGE should be stated EXACTLY. Information on CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58457

CERTIFICATE OF DEATH.

89 D 58457

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 E. Clement ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonio Becker

(Residence in Baltimore: No. 639 E. Clement St.; 26 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct. 27, 1870 (Month) (Day) (Year)

7-AGE. 51 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 639

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Charles Waller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Hanna Niemann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred. Becker

(Address) 639 E. Clement St

15 NOV 10 1921 Filed..... 191... Burial Permit Issued by ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~October~~ November 7, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 30 1921, to Nov. 7 1921, that I saw her alive on Nov. 7 1921, and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

.....

Acute Bronchitis

..... (Duration) ...yrs. ...mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac failure

..... (Duration) ...yrs. ...mos. 1 ds.

(Signed) Robt. C. P. Schmidt M. D.

Nov. 9, 1921. (Address) 1315 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, 11/10, 1921.

20-UNDERTAKER C. I. Fanning

ADDRESS 1460 Gilmor

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

Dr. Tidlow

D 58458

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58458

92-081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 S Ellwood Ave. (St.) 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Anderson Stevens

(a) RESIDENCE No. 720 S. Ellwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Stevens

6 DATE OF BIRTH (month, day, and year) Jan. 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer) Md. a. a. Chemical

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Rock Hall, Md.

PARENTS

10 NAME OF FATHER Samuel Steward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Hall, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Matilda Stevens

(Address) 720 S. Ellwood av.

15 Filed NOV 10 1921 Recorded

Burial ... Removal

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 9, 1921, that I last saw him alive on Nov 8, 1921, and that death occurred, on the date stated above, at 6. a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) H H Tidlow, M. D.

9/9, 1921 (Address) 3N S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov. 11 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1700 Fleet St.

N.B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

John H. Velten

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 58459

CERTIFICATE OF DEATH Velten

D 58459

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3041 Stafford ST. 70 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Henry Velten Sr

(Residence in Baltimore: No. 3041 Stafford St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Sept 1st (Month) (Day), 1848 (Year)

7 AGE: 73 yrs. 2 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Baker
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Henry Velten Jr

(Address) 1615 Fulton Ave

Filed NOV 10 1921 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November (Month) 8 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1921. to November 8 1921

that I saw h-- alive on November 8, 1921.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 2 yrs. 6 mos. ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Nov 8, 1921 (Address) 1328 S Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery Nov DATE OF BURIAL: 11 ~, 1921

20 UNDERTAKER: Geo J Weber ADDRESS: 503 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58460 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58460

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob T Brehm

(a) RESIDENCE. No. 1335 W. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Brehm

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 yrs	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker 047

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Brehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Christina Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Jacob T Brehm

(Address) 1335 W Lombard St

15 Filed NOV 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/6, 1921, to 11/9, 1921, that I last saw him alive on 11/8, 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach colon Sigmoid & and mesenteric glands Hemorrhage Exhaustion

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cachexia Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1335 W Lombard St

Did an operation precede death? yes Date of 11/8/21

Was there an autopsy? No.

What test confirmed diagnosis? Open operation

(Signed) W. D. Doughton, M. D.

, 19 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL CEM	NOV 11 1921
20 UNDERTAKER	ADDRESS
ROBERT BROOKS & SON	175 CALHOUN ST

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58461

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Calvert St. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Devall

(a) RESIDENCE. NO. 1102 N. Eutaw ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oysterman D45

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Devall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Devall

(Address) 1102 N. Eutaw St.

15 Filed . 19

Robert F. Harrison,

Registrar

NOV 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1921, to Nov. 9, 1921, that I last saw him alive on Nov. 9, 1921, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, hypostatic pneumonia acute pulmonary oedema (duration) 2 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory.

(Signed) Fred. A. Ries, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/12" 1921
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	118 W. Mt Royal ave.

N. B.—WRITE PLAINLY, WITH INK. ALL INFORMATION should be stated EXACTLY. PHYSICIANS should have AGE carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58462 — 31 — D 58462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 E. Lexington ST.; B WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Jackson

(a) RESIDENCE. No. 1230 E. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	✓		

8 OCCUPATION OF DECEASED Domestic

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Columbus Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Belle Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C / N.C.

14 Informant Robert Turner
(Address) 1230 E Lexington St

15 Filed 19 Robert P. Harrison, Registrar
NOV 1 01921
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1921, to Nov 9, 1921, that I last saw h[illegible] alive on Nov 9, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

11-10, 1921 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
High Point, N.C	Nov 11 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. If information is not known, state that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it CAUSE OF DEATH is very important. See instructions on back of certificates.

D 58463 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58463

CERTIFICATE OF DEATH.

X 175-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt. Sin. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elias Goldberg

(Residence in ~~Baltimore.~~ No. 1451 Prospect Ave, N.Y. city St.; yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Oct. 12, 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)..... Pvt.

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Louis Goldberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Minnie Rubin

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Goldberg

(Address) 1451 Prospect Ave

15- Robert P. Harrison N.Y. City

NOV 10 1921 19..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner's (Inquest, autopsy or inquiry.) Jury find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Automobile accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Nov. 10, 1921. (Address) 2. 812 E. Fayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 6 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Near Reisterstown, Md.

Former or usual residence 1451 Prospect Ave

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New York N.Y.	Nov. 10, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Baltimore

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58464

CERTIFICATE OF DEATH.

79-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3216 Foster Ave. ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amylora Hartman.

(a) RESIDENCE. NO. 3216 Foster Ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Attended school.
(b) General nature of industry, business, or establishment in which employed (or employer): 001
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore city.

PARENTS

10 NAME OF FATHER: Frank M. Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. city.

12 MAIDEN NAME OF MOTHER: Goldie M. Hartlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. city.

14 Informant: Frank M. Hartman
(Address) 3216 Foster Ave

15 Filed NOV 10 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1921, to Nov 8, 1921, that I last saw her alive on Nov 7, 1921, and that death occurred, on the date stated above, at 6 O.M. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) chronic Valvular Heart Dis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Nov. 11 192
20 UNDERTAKER: Lilly & Zeile	ADDRESS: 403 L W St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58465

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 E. Madison St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry James Campbell

(a) RESIDENCE. NO. 1828 E. Madison St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER David Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Mc Murtrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mr. H. T. Nelson
(Address) 3501 Fairview Ave.

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

V 101921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11- 1915, to Nov. 10. 1921, that I last saw him alive on Nov. 9- 1921, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Loco-motor Ataxia with Paraplegia & atrophic about 25 yrs (duration) yrs. mos. ds. Otitis

CONTRIBUTORY (Secondary) General debility & marasmus two years or more (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carlton M Loop, M. D.

19 (Address) 1107 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov. 11th 1921
20 UNDERTAKER Joseph B. Cook's	ADDRESS 1003 N. Bath St

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Mannie Malachi)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58466

CERTIFICATE OF DEATH.

91 D 58466

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1424 Carrish Street ST.: Baltimore WARD: 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mannie Malachi

(a) RESIDENCE. No. 1424 Parrish ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mannie Malachi

6 DATE OF BIRTH (month, day, and year) ? ? 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jan 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Boyd Malachi

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Rose Beyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Annie Malachi

(Address) 14 N. Parrish St

15 Filed Robert P. Harrison, Registrar

NOV 1 01921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10-1921

17 I HEREBY CERTIFY, That I attended deceased from 11-7-1921, to 11-10-1921, that I last saw him alive on 11-9-1921, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

P. Pneumonia

(duration) 4 da. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1424 Parrish

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. R. Boston M. D.

, 19 (Address) 1618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Nov 11 19

20 UNDERTAKER James H. Dennis

ADDRESS 1307 Pennsylvania

Should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be of certificates. See instructions on back of certificates. CAUSE OF DEATH is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho. not tuberculous

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 58467

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 ✓D 58467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 844 N Sharp ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Matthews

(a) RESIDENCE. NO. 844 N. Sharp ST., 22 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Glass Factory

(c) Name of employer: Standard Glass Co.

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: James Matthews
(Address) 844 N Sharp St

15 NOV 11 1921 BOARD OF HEALTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/ 19 21

17 I HEREBY CERTIFY, That I attended deceased from 9/19/ 19 21, to 10/9/ 19 21, that I last saw h[illegible] alive on 11/8/ 19 21, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Failure of Compensation
Duration about 2 days
Mitral Regurgitation
CONTRIBUTORY (Secondary) about (duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

11/11/ 19 21 (Address) 908 N Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov. 11 1921
20 UNDERTAKER	ADDRESS
L. H. Brown & Son	108 W. Monty

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58468

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH (Westport)

CITY OF BALTIMORE. (No. 135 Maryland Ave ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Kramer

(Residence in Baltimore: No. 135 Maryland Ave Westport St.; 62 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 14 (Day), 1859 (Year)

7-AGE, 62 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): and Banker

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER, John H Kramer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Henretta Thalman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Loyd Kramer

(Address) Westport

NOV 11 1921 Filed....., 191... SCHEY & KRAUTH Burial Permit Required

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 9 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1921, to Nov 9 1921, that I saw him alive on Nov 8 1921, and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows: Chronic Indigestion

Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) Raymond Dahlman M. D.

Nov 10, 1921 (Address) Linthicum

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 12th, 1921.

20-UNDERTAKER Josiah Syfer — ADDRESS 1600 W North Ave

N. B.—Every item of information should be carefully considered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58469

REGISTERED NO. 79 D 58469

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Burgess

(a) RESIDENCE. NO. 544 N Hoffman St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Baltimore yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	? 48	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Calista Riggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) ROBERT F. KRAUTH

15 Attest NOV 11 1921 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1921, to Nov 9th, 1921, that I last saw h.... alive on Nov 9th, 1921, and that death occurred, on the date stated above, at 1:20 a. m.

The CAUSE OF DEATH* was as follows:

Embolism & Thrombosis (Brain) not traumatic

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Disease (mitral) (duration) yrs. 5 mos. 15 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Edwin Boles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Nov. 3 1921

20 UNDERTAKER David Easton

ADDRESS 916 Vernon ave

N. B.—WRITE PLAINLY. All questions must be carefully answered. If any information is not supplied, AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58470

D 58470

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Taylor

(a) RESIDENCE. No. 301 N. Caroline St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Jane Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Priscilla Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed NOV 11 1921 ROBERT I. KRAUTZ Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1921, to Nov 10th, 1921, that I last saw h.... alive on Nov 10th, 1921, and that death occurred, on the date stated above, at 5 50 a. m.

The CAUSE OF DEATH* was as follows:
Aortic insufficiency

(duration) yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edwin Bowles Andrus, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lamel Lawn	Nov 11th 1921
20 UNDERTAKER Daniel Carbon	ADDRESS 916 Park

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. N. B. ... TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58471

CERTIFICATE OF DEATH.

118 D 58471

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Franklin Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Strong

(a) RESIDENCE. NO. 2244 McElderry St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Slater

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Ida Maguire

(Address) 2244 McElderry St

NOV 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1921, to Nov 9, 1921, that I last saw her alive on Nov 9, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency 3 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Acute Hypertrophy & Pancreatitis 1 mo

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 19 21

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Hugh Blount, M. D.

, 19 (Address) 16 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezer Cemetery	Nov 12 1921
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. The information should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58472

CERTIFICATE OF DEATH.

126 D 58472

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Phillip Kraft

(a) RESIDENCE. No. Lisson Ave (Roynel Heights WARD.
(Usual place of abode) Unknown (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) 3-2-543

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Manager

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John ? Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 11 1921 19 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-29, 1921, to 11-10, 1921, that I last saw him alive on 11-10, 1921, and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Eugene C Shute, M. D.

11-10, 1921 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL Nov 12 1921

20 UNDERTAKER J. J. Cowan & Son ADDRESS 901 Hollins St.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58473

CERTIFICATE OF DEATH.

119 D 58473

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 N. Bruce ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Banks

(a) RESIDENCE. No. 1420 N. Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William Banks

6 DATE OF BIRTH (month, day, and year) 4-3-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Elijah Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Shroud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Margaret Banks (Daughter)
(Address) 1723 Gorman St.

NOV 11 1921
Filed

ROBT. J. BRUCE
Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10-1921

17 I HEREBY CERTIFY, That I attended deceased from 10-26, 1921, to 11-10, 1921, that I last saw h~~e~~r alive on 11-9-1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

037

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Above address

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) George C. Page, M. D.

(Address) 170 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edward Mt. Auburn	Nov 13 1921
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 N. Carey

N. B.—WHITE LEAVES. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition than uremic coma.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58474 — 37 — D 58474

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 725 School St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Chinn

(a) RESIDENCE. No. 725 School ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Chinn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Perry
(Address) 317 Presstman St

15 Filed NOV 11 1921 19 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-30-, 1921, to 11-9-, 1921, that I last saw h.. alive on 11/8/21, 19..., and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cystitis

1/30/21 to 11/9/21
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm B Bok, M. D.

, 19 (Address) 1618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 11 1921
20 UNDERTAKER	ADDRESS
Edward Ringgold	1463 Carey

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ovarian cyst.
Luetic.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58475

CERTIFICATE OF DEATH.

138 D 58475

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Providence Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Gertrude Thompson

(Residence in Baltimore: No. 1704 Presstman St. 21 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Mar 27th, 1900 (Month) (Day) (Year)

7-AGE, 21 yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER. James Thompson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Lucy Dixon

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Thompson

(Address) 1704 Presstman St

15 NOV 11 1921 Burial Permit Clerk

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 6th, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th 1921, to Nov 6th 1921, that I saw h er alive on Nov 6th 1921, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Child Birth

(Duration) yrs. mos. ds.

(Signed) Harry F Brown M. D.

Nov 8th, 1921. (Address) 601 Presstman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Kings ale Wbf Baltimore Va DATE OF BURIAL, Nov 11, 1921.

20-UNDERTAKER Edward Bungard ADDRESS 1463 N Carey St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58476

61-001

CERTIFICATE OF DEATH.

D 58476

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 Augusta Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Coleman

(Residence in Baltimore: No. 432 Augusta Ave St.; 10 yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, or DIVORCED.~~ (Write the word.) Single

6-DATE OF BIRTH, Oct. 16, 1908 (Month) (Day) (Year)

7-AGE, 13 yrs. — mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country). Newark N.J.

PARENTS.

10-NAME OF FATHER, Edgar H Coleman

11-BIRTHPLACE OF FATHER (State or Country) Port Allegany Pa

12-MAIDEN NAME OF MOTHER Lydia Edmunfield

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar H Coleman

(Address) 432 Augusta Ave

15- NOV 11 1921 BOARD OF HEALTH

Filed ..... 1921 Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7th 1921, to Nov. 10th 1921, that I saw her alive on Nov. 10th 1921, and that death occurred, on the date stated above, at 10 40 p.m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

6

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D W Keown M. D.

Nov. 11th, 1921 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Nov. 11, 1921

20-UNDERTAKER A D Hepperle — ADDRESS 2236 Fred'k Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58477

CERTIFICATE OF DEATH.

64

D 58477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 404 E 23 ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Smith

(a) RESIDENCE NO. 404 East 23 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic — 070

(b) General nature of Industry, business, or establishment in which employed (or employer) Private home work

(c) Name of employer ←

9 BIRTHPLACE (city or town) (State or country) Live in Balt 22 years Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hayden Smith

(Address) 404 East 23 St

15 Filed NOV 11 1921 ROBT. A. ELLIOTT Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1921, to Nov 8 1921.

that I last saw her alive on Nov 8 1921,

and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Complete)

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) O. Gabriel Chevallier, M. D.

Nov. 1924 (Address) 1534 — E. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem — DATE OF BURIAL Nov 11 1921

20 UNDERTAKER Mrs Robert A Elliott — ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58478

D 58478

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 St Mary ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Craven

(a) RESIDENCE. No. 419 St Mary ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Live in Ball-35-years
(State or country) Near- Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Jenie Cravin
(Address) 419 Saint-Mary-st

15 Filed . 19 NOV 11 1921

Burial Permit Issued Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 16th, 1921, to Nov 8th, 1921,

that I last saw him alive on Nov 8th, 1921,

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Symptoms

(Signed) W H Pearce, M. D.

, 19 (Address) 2105 St. Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 11, 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Ashland Av

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58479

CERTIFICATE OF DEATH.

170 D 58479

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 Harwood Court ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula E. Shenton

(a) RESIDENCE. NO. 3407 Harwood Court ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Thomas E. Shenton

6 DATE OF BIRTH (month, day, and year) Sept. 6 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Saml J. Cannon

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Susie J. Simmons

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co.
(State or country) Md.

14 Informant Thomas E. Shenton
(Address) 3407 Harwood Court

15 Filed NOV 11 1921 HOLLY A. FRANTZ Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Nov 10, 1921, that I last saw her alive on Nov 9, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A B Fillow M. D.

11/10, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Nov. 12 1921
20 UNDERTAKER Zinkler + Zinkler	ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH INK. ... should be stated EXACTLY. ... mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be properly classified, so that it may be CAUSE OF DEATH in plain terms, so that it ... See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

58480

CERTIFICATE OF DEATH.

91 D 58480

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5 Suburban Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert F Crafton

(a) RESIDENCE NO. 5 Suburban Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Clara Faithful

6 DATE OF BIRTH (month, day, and year) Nov. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia Dont Know Town Dont Know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) William Crafton 642 Dumbarton ave

15 Filed NOV 11 1921 19 ROBERT A [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Nov 9, 1921, that I last saw him alive on Nov 9, 1921, and that death occurred, on the date stated above, at 5 30 Pm.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm M Wright, M. D.

, 19 (Address) 1801 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood. DATE OF BURIAL Nov 12 1921

20 UNDERTAKER E A Windsfeld ADDRESS 501 E 22

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. INFORMATION should be carefully supplied

Spec.—8-24-14—M. & T.—2000 Bks.

Frances E. Fry. ✓

D 58481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 58481

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 N Charles ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Elizabeth Fry

(Residence in Baltimore: No. 1405 N Charles St.; 71 yrs., 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec 28, 1849. (Month) (Day) (Year)

7-AGE, 71 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John H. Joines

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Scarborough Beauchamp

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catharine A. Joines

(Address) 1405 N. Charles St.

15- Filed NOV 11 1921, 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1913, to Nov 10 1921, that I saw h alive on Nov 2 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Fred. D. Lewis M. D.

....., 191... (Address) 25 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Nov 13, 1921.

20-UNDERTAKER W. M. Rountree — ADDRESS 223 N. Mt.

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58482

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 539 W. Barre ST.: 22 WARD)

2-FULL NAME Charles H. Kyler

(a) RESIDENCE. NO. 539 W. Barre ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88 yrs	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Last Tayer

(Address) 1170 N. Broadway

15 Filed NOV 11 1921 ROBERT F. BEAUTLE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7th 1921, to Nov 9th 1921, that I last saw him alive on Nov 8th 1921, and that death occurred, on the date stated above, at 12 midnight.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart. (Aortic) (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Senile Debility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) D. H. Lawell, M. D.

11/11, 1921 (Address) 140 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Nov. 11 1921

20 UNDERTAKER Samuel J. Hemsley

ADDRESS 1708 Bolton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE ... should be stated EXACTLY. PHYSICIANS ... mation should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58483

CERTIFICATE OF DEATH.

102 D 58483

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Offord ST.: 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Massey

(a) RESIDENCE. No. 530 Offord ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Curt Massey

6 DATE OF BIRTH (month, day, and year) Nov 7, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 086

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos. D. H. Massey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Victoria Bias

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Victoria Massey (Address) 530 Ford St

15 NOV 11 1921 BOLLA & ARNOLD Registrar

Burial ... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV. 7 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1921, to NOV. 7 -, 1921, that I last saw her alive on NOV. 7 -, 1921, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Gastric ulcer with Pyloric Obstruction

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Edw. J. Wheatley, M. D.

11/11/1921 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Lawn	Nov 11 1921
20 UNDERTAKER	ADDRESS
Saml F. Hensley	1915 Madison

N. B.—WRITE PLAINLY. WITH EXCEPTION OF NAME AND RESIDENCE, ALL INFORMATION should be stated EXACTLY. PHYSICIANS should be careful that AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58484

CERTIFICATE OF DEATH.

41 D 58484

REGISTERED NO.....

1-PLACE OF DEATH 3600 York Rd -

CITY OF BALTIMORE: (No. ..... ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Quigley Herring

(a) RESIDENCE. No. 3600 York Rd - ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James McNeal Herring

6 DATE OF BIRTH (month, day, and year) Dec 2 - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 yrs	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Shippensburg Pa - Pa

PARENTS

10 NAME OF FATHER Robert Quigley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Co. Pa.

12 MAIDEN NAME OF MOTHER Eleanor Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Co. Pa

14 Informant Robert J. Herring (Address) 3600 York Rd.

NOV 11 1921 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1921

17 I HEREBY CERTIFY, That I attended deceased from September, 1920, to Nov. 10, 1921, that I last saw her alive on Nov. 9, 1921, and that death occurred, on the date stated above, at 6 a - m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Sept. 20, 1920

Was there an autopsy? No.

What test confirmed dingnosis? Clinical - Microscopic

(Signed) H. B. McElwain, M. D.

, 19 (Address) 31 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	11/12/1921
20 UNDERTAKER J. E. Walker	ADDRESS 723 W Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE ... stated EXACTLY. PHYSICIANS should state ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... of certificates.

Spec.—1-10-21—M&T—1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58485

CERTIFICATE OF DEATH.

80

REGISTERED NO. D 58485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 S. Charles St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Armiger

(a) RESIDENCE NO. 1518 S. Charles St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Armiger

6 DATE OF BIRTH (month, day, and year) June 18, 1858

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
63	4	23	

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Police Sergeant

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Jesse Armiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Amanda Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mary C. Arniger, (wife)

(Address) 1518 S. Charles St.

15 NOV 11 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from November 6, 1921, to November 10, 1921, that I last saw him alive on November 9th, 1921, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Obstruction of the Coronary Arteries

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Otto M Reinhardt, M. D.

Nov, 11, 1921 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Cem	11/12 1921
20 UNDERTAKER	ADDRESS
J. Few McCully	130 E Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should see that all information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58486

D 58486

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Fredrick Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward S. Johnson

(Residence in Baltimore: No. 802 Fredrick Ave. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Feby 15, 1847
(Month) (Day) (Year)

7-AGE, 74 yrs. 8 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Bricklayer
(b) General nature of Industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, dont Know

11-BIRTHPLACE OF FATHER (State or Country), dont Know

12-MAIDEN NAME OF MOTHER Sabina Zimmer

13-BIRTHPLACE OF MOTHER (State or Country), dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Katharine Armacost

(Address) 1518 S. Charles

15- NOV 11 1921 BOARD OF HEALTH

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. November 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16 1920, to November 9 1921, that I saw h[illegible] alive on Nov 9 1921, and that death occurred, on the date stated above, at 8-10 m.

The CAUSE OF DEATH* was as follows:

.....

.....

Chronic Nephritis

..... (Duration) yrs. 18 mos. — ds.

CONTRIBUTORY (Secondary) Senile Dementia

..... (Duration) 2 yrs. — mos. — ds.

(Signed) Robt. O. Pickett M. D.

Nov. 11, 1921. (Address) 1738 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Pk Cem

DATE OF BURIAL, Nov 12, 1921

20-UNDERTAKER James McCully

ADDRESS 130 E. Fort

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PROFESSION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58487

CERTIFICATE OF DEATH.

42 D 58487

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 623 W. Lee ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 623 W. Lee William Brown

(Residence in Baltimore: No. 623 W. Lee St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Married

6-DATE OF BIRTH, Jan (Month) 21 (Day), 1879 (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Josephine Brisbee

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edla Brown

(Address) 623 W. Lee St.

15- NOV 11 1921 Filed ..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1921, to Nov 7 1921, that I saw h[illegible] alive on Nov 6 1921, and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

..... (Duration) ..... yrs. ..... mos. 1 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. 12 ds.

(Signed) C. N. Flowers M. D.

Nov 12, 1921 (Address) 711 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Nov. 11-21 191...
20-UNDERTAKER	ADDRESS
R. C. Gross	1405 McElderry St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS filling this CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 58488

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D 58488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2841 Pennaave ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Baker

(a) RESIDENCE NO. 2841 Pennaave ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Baker

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses Spanger

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Unkan

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 Essex

15 Filed NOV 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1918, to Nov 11, 1921, that I last saw h[illegible] alive on Nov 10, 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 hr.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Michael A. Abrams, M. D.

Nov 11, 1921 (Address) 2360 Eutaw place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	11-11 1921

20 UNDERTAKER Jack Lewis, ADDRESS 1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED OUT EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58489

CERTIFICATE OF DEATH.

155

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2-FULL NAME Herman J. Martin

(Residence in Baltimore: No. 1650 Perkins Av St.; yrs.. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June 11, 1858 (Month) (Day) (Year)

7-AGE, 63 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... Baker
(b) General nature of industry, business, or establishment in which employed (or employer).... 603

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).... Anna Martin

(Address).... 1650 Perkins Av

15-

NOV 11 1921 191.... Burial Permit 9118

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 9, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an....inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said....Jury.... (Inquest, autopsy or inquiry.) find that said deceased came to....death on the day stated above.

The CAUSE OF DEATH* was as follows:

....Carbuncle neck and Pneumonia

Contributed by Alcoholism

Probably (Duration) ....yrs. 1 mos.....ds.

CONTRIBUTORY.... (Secondary)

.... (Duration) ....yrs.....mos.....ds.

(Signed)....M. D. (Coroner)

Nov 11 1921 (Address) 763 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 11 yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Conn — DATE OF BURIAL, Nov 12th, 1921

20-UNDERTAKER C. J. Solomon and Son — ADDRESS 1039 Monroe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1009 Bks.

15-15-5-8

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-36

D 58490

CERTIFICATE OF DEATH.

D 58490

1-PLACE OF DEATH

CITY OF BALTIMORE: No JOHNS HOPKINS HOSPITAL ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kruszynski

(a) RESIDENCE. No. 2511 East Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-20-20

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Kruszynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Frances Rosenski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15- NOV 11 1921 Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1921, to 11-10, 1921, that I last saw him alive on 11-10, 1921, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Rickets and Scurvy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? x ray

(Signed) Horace G. Stewart, M. D.

11/10, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	Nov 13" 1921
20 UNDERTAKER W. F. Sadowski.	ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58491

CERTIFICATE OF DEATH.

91

D 58491

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 N. Pratt St. St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank B Neuman

(Residence in Baltimore: No. 1420 N. Pratt St. St.; ..... yrs., 4 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
M	W	S

6-DATE OF BIRTH, August (Month) 5 (Day) 1921 (Year)

7-AGE, ... yrs. 4 mos. 5 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 1420 N Pratt St

PARENTS.

10-NAME OF FATHER, Frank Neuman

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Lena Weiss

13-BIRTHPLACE OF MOTHER (State or Country), Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Neuman

(Address) 1420 W Pratt St

15-

Filed NOV 11 1921 19.. [illegible]

BURIAL PERMIT Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 191.., to Nov 10 191..,

that I saw h.. alive on Nov 10 191..,

and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

.....Bronchopneumonia.....

.....

.....

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar E Trader M. D.

Nov 10, 191.. (Address) 1520 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Nov 12, 191..
20-UNDERTAKER	ADDRESS
John J Fulde	1200 W Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Reinke

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

40 D 58492

D 58492

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alma Reinke

(Residence in Baltimore: No. 225 S. Woodyear St.; 30 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... Mar (Month) 6 (Day) 1887 (Year)

7-AGE, 34 yrs. 8 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Albert Jaenicke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Jena Reiman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Reinke

(Address) 225 S. Woodyear

15- NOV 11 1921 Filed ..... 191... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6 1921, to Nov. 10 1921, that I saw her alive on Nov. 10 1921, and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis M. Finke M. D.

Nov. 10, 1921. (Address) 6.5.74.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 12, 191[illegible]

20-UNDERTAKER John J. Fields — ADDRESS 1200 W. Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58493 ✓ 170 D 58493

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Balto City Jail ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Iran Berkey

(Residence in Baltimore: No. 222 N. Greenstreet)

Sex Male Yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1870 (Year)

7-AGE, 47 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER, George Berkey

11-BIRTHPLACE OF FATHER (State or Country). Pa

12-MAIDEN NAME OF MOTHER Sarah Shoffer

13-BIRTHPLACE OF MOTHER (State or Country), Johnstown Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Balto

15- Filed NOV 14 1921, 191.... BOSLEY & FOUTZ Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11 (Month) 21 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmon. Edema

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

Duration yrs. mos. ds.

(Signed) M. D. (Coroner)

Nov 21, 1921 (Address) 1637 Ky

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL. Johnstown, Pa. DATE OF BURIAL, 11-11-, 1921

20-UNDERTAKER Jack Lewis, ADDRESS 1411 E. Balto.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form 6-9-19—H. P. Co.—1000 Bks.

D 58494

151990 58494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 104 D 58494

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Irene E Evans

(a) RESIDENCE. NO. Back River Neck Road, Essex, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-13-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed NOV 12 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1921

17

I HEREBY CERTIFY, That I attended deceased from 11-5, 1921, to 11-10, 1921, that I last saw her alive on 11-10, 1921, and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not Dysentery).

(duration) yrs. mos. 13 ds. (terminal)

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

18 11, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov. 14 1921
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Sons	Fullerton Md

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151906 D58494 — X63-D58494

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Irene Evans

(a) RESIDENCE. NO. Welly Rock Road ST.. WARD. Parville Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 31 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	28	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8th, 1921, to Nov. 10th, 1921, that I last saw h.r alive on Nov. 10th, 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute poliomyelitis

(Corrected Cause of Death)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY none
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal Fluid —

(Signed) Horace G. Stewart, M. D.

11/23, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state NAME should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58495 D 58495 37 V 58495

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 32 E. Hamilton ave (St.) Hamilton (Ward) 21

2-FULL NAME Henry Fomme

(a) RESIDENCE. No. 32 E. Hamilton Ave St. Hamilton Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer (Steam)

(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer J. Hopkins Hospital Balto.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER August Fomme

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Meta Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August Fatmme
(Address) 32 E. Hamilton ave

15 Filed . 19 Robert P. Harrison, Registrar

NOV 12 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9. 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 9 1919, to Nov 9 1921, that I last saw h alive on Nov 9 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion, Myocarditis Nephritis and Probable Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Locomotor Ataxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Simms, M. D.

Nov 10, 1921 (Address) 4706 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 12 1921
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Son	Fullerton

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58486 D 58496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. D 58496

64 152 50 58486 871

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Pulaski ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Lewis

(a) RESIDENCE. No. 1716 Pulaski ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 12th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Esther Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Emily Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Mary Thompson
(Address) 1716 Pulaski St.

15 Filed NOV 12 1921, Robert P. Harrison, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be stated EXACTLY. CAUSE OF DEATH should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1921, to Nov. 9, 1921, that I last saw him alive on Nov. 9, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Surgeon

(Signed) John D. Quinn, M. D.

11/14/21 (Address) 1507 N. Charles Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Nov 14 1921

20 UNDERTAKER Hammond & Thiss ADDRESS 1364 Mary

D 58497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58497

CERTIFICATE OF DEATH.

167

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md General Hosp. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth W. Lire

(Residence in Baltimore: No. 719 N. Payson St.)

St.: 62 yrs., 3 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, ... Aug. (Month) 1st (Day), 1859 (Year)

7-AGE, 62 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter Fischer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva H. Shafer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel E. Byers

(Address) 719 N. Payson St.

15-

Filed....., 191..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

11 2 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 11th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd & 3rd, degree burns of body, (Duration) ..... yrs. ..... mos. 3 hrs. ..... ds.

CONTRIBUTORY (Secondary) accidental (Clothes caught fire from stove.)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy (Coroner) M. D.

Nov. 11, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. In the of death.....yrs.....mos. 1 da. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

719 N. Payson St.

Former or usual residence.....Same.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Nov. 12, 1921

20-UNDERTAKER Wm. Mrs. John H. Teufel & Son ADDRESS 80 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. DO NOT USE PENCIL.

Spec.—1-10-21—M&T—1500 Bks.

(Zagnoba)

D 58498 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58498

CERTIFICATE OF DEATH. 120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 Eastern ave ST., V WARD)

2-FULL NAME Ludwika Zagnoba

(a) RESIDENCE NO. 1830 Eastern ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	10	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Vincent Zagnoba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Pawlowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Vincent Zagnoba (Address) 1830 Eastern ave

15 Robert P. Harrison, Registrar

NOV 12 1921 .19.. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 .1921. to Nov. 10 .1921.

that I last saw her alive on Nov 10 .1921.

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
& Chronic Bright's
Kidney Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hlr

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. A Geary M. D.

(Address) 2600 E Balto Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Nov 14 1921

20 UNDERTAKER John M Weber 1803 — ADDRESS Bank St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

(Grzebowski)

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58499

CERTIFICATE OF DEATH.

19 D 58499

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 237 S Duncan ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Grzebowski

(a) RESIDENCE. NO. 237 S Duncan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonina Grzebowski

6 DATE OF BIRTH (month, day, and year) Dec 2

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor (4)

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mrs Antonina Grzebowski 237 S Duncan St

15 Filed Robert P. Harrison, Registrar

NOV 12 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 9, 1921, that I last saw h... alive on Nov 9, 1921, and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Aortic Insufficiency

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W J Baylis M. D.

11/10/19/21 (Address) 216 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Nov 12 1921

20 UNDERTAKER: John A Weber — ADDRESS: 1803 Bank St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58500

CERTIFICATE OF DEATH.

15 MD 58500

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Jackson ST.: 24th WARD)

2-FULL NAME Ruth C. Adams

(a) RESIDENCE. NO. 1409 Jackson ST.: 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13 21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ida Nisson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant E. Adams
(Address) 1409 Jackson

15 Filed Nov 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 11, 1921, that I last saw h[illegible] alive on Nov 11, 1921, and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma
Duration 10 D

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Bad nutrition

(duration) ... yrs. ... mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

..., 19 (Address) 837 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Nov 15 1921
20 UNDERTAKER E. Schloman & Son	ADDRESS 1339 Monroe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 12 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malnutrition since birth. No gastro intestinal disturbance. Very puny baby. Mother very thin & puny. Convulsions due to dentition

Spec.—1-10-21—M&T—1500 Bks.

D 58501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58501

CERTIFICATE OF DEATH.

150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1621 E Eager ST. WARD)

2-FULL NAME Margaret E. Little

(a) RESIDENCE NO. 1621 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J. Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Florence E. Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. John J. Little

(Address) 1621 E Eager St

15 Filed Robert P. Harrison, Registrar

NOV 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from November 3 1921, to November 11 1921,

that I last saw h alive on November 10 1921,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) yrs. mos ds.

Convulsions

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Miles K. A. Meyer M. D.

(Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Nov. 14 1921

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58502 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58502

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor, St.: 10 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Cahill,

(a) RESIDENCE. No. Preston & Valley Sts. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	—	—	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Cahill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Redmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence.

(Address) Preston & Valley

15 Filed Nov 12 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1921, to Nov 11 1921.

that I last saw her alive on Nov 6 1921.

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Nov 11, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Nov 12 1921
20 UNDERTAKER	ADDRESS
J. C. Windfield	94 Broadway

NOV 12 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58503

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 12 N. Durham ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Becker

(a) RESIDENCE. No. 12 N. Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 - 1915

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John M. Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Rumbel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs John Becker
(Address) 12 N. Durham st.

15 Filed Robert T. Harrison, Registrar

NOV 12 1921

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1921, to Nov 11, 1921, that I last saw him alive on Nov 10, 1921, and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bright Disease

(duration) yrs. / mos. / ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Finger Clubbed

(Signed) A. E. Eldridge, M. D.

. 19 (Address) 1437 N. Bway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem	Nov. 11 1921

20 UNDERTAKER Jos J. Hess ADDRESS 156 N. Linwood

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. OCCUPATION should be stated EXACTLY. PHYSICIANS should be mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58504 104 D 58504

CERTIFICATE OF DEATH.

D 58504

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Simon

(a) RESIDENCE. NO. 117 E. Monument ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-10-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Simon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Smoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 12 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 1921, to 11-10, 1921, that I last saw him alive on 11-10, 1921, and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery) (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Hospital JHH.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wright.

(Signed) Horace G. Stewart, M. D.

11/11, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health. NOV 11 1921

per Wm. E. WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58505

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Bennington Ave ST.: 25 WARD)

2-FULL NAME Vojtech Paranicky

(a) RESIDENCE. NO. 1118 Pennington Av ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Paranicky

6 DATE OF BIRTH (month, day, and year) [illegible] 82

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coiner 040

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Car Wheel Wks

(c) Name of employer Maryland Car Wheel Wks

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER [illegible] Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER [illegible] Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Otto Paranicky

(Address) 1118 Pennington Av

15 Filed Nov 12 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7th 1921, to Nov. 7th 1921, that I last saw h[illegible] alive on Nov. 7th 1921, and that death occurred, on the date ~~stated above~~, at 1 P. m. Nov 11 1921

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

Antecedent — (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William Dyer, M. D.

19 (Address) 816 Hennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Nov 14 1921

20 UNDERTAKER Fred Crawford ADDRESS Pennington Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should see that information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58506

CERTIFICATE OF DEATH.

120

D 58506

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 W. Madison ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Malcolm

(a) RESIDENCE. No. 222 W. Madison ST., 11 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 5 ds. How long in U. S., If of foreign birth? 67 yrs. 11 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A Malcolm

6 DATE OF BIRTH (month, day, and year) December-5-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist 055

(b) General nature of industry, business, or establishment in which employed (or employer) Dentistry

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James Malcolm

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachael P. Cole

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Sarah A Malcolm (wife)

(Address) 222 W Madison St

15 NOV 12 1921 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1921, to Nov. 10, 1921, that I last saw him alive on Nov. 10, 1921, and that death occurred, on the date stated above, at 11 6° m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edgar P. Saudrock, M. D.

, 19 (Address) 15 West Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dover - New Hampshire	Nov-12-1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58507

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Norman ave ST.: 10 WARD)

2-FULL NAME Wilbur L Wheeler

(a) RESIDENCE. NO. 513 Norman ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ora M. Wheeler

6 DATE OF BIRTH (month, day, and year) Sept. nov 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work manager. Overall trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Michaels md

PARENTS

10 NAME OF FATHER Wm L Wheeler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Emma Sexton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Ora M. Wheeler

(Address) 513 Norman ave

15 Filed 19 Registrar

NOV 12 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26 1921, to Nov 10 1921, that I last saw him alive on Nov 10 1921, and that death occurred, on the date stated above, at 3:50 a.m.

The CAUSE OF DEATH* was as follows:

Neoplasm of lung & spine

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J Coolahan, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 2 1921
20 UNDERTAKER Robt F Tanner Sons	ADDRESS 1443 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant neoplasm originating in lung.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58508

CERTIFICATE OF DEATH.

D 58508

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fred Lubin

(a) RESIDENCE. No. Newark N.J. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) ? 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jewler

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

PARENTS

10 NAME OF FATHER Samuel Lubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Villna Russa.

12 MAIDEN NAME OF MOTHER Anna Aronofsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cookna Russia

14 Informant Fannie Lefkowitz.
(Address) Newark N. J.

15 Filed 19 Robert P. Harrison, Registrar

NOV 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1921.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1920, to Nov. 12, 1921, that I last saw him alive on Nov. 12 1921, and that death occurred, on the date stated above, at 9 34 a.m.

The CAUSE OF DEATH was as follows:

General Lymphosarcomatosis

Over

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) ✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 21, 1920

Was there an autopsy? No

What test confirmed diagnosis? Pathological section gland

(Signed) Arthur C. Primrose, M. D.

11/12. 1921 (Address) 1418 Cantaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newark New Jersey	Nov 12 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	142 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58509 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58509

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3727 Mt. Pleasant Ave. ST.: 26 WARD)

2-FULL NAME Rosa Gensler

(a) RESIDENCE. NO. 3727 Mt. Pleasant Ave ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Gensler.

6 DATE OF BIRTH (month, day, and year) March 25-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Behm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Theresa Foelter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John A. Gensler. (Address) 3705 E. Pratt St.

15 Filed NOV 12 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1921, to Nov. 9th, 1921, that I last saw her alive on Nov 9th, 1921, and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edel V Athey, M. D.

Nov 9 1921 (Address) 1003 Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apuce.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov 12 1921
20 UNDERTAKER Tilly & Zeiler	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58510 ✓ D 58510

CERTIFICATE OF DEATH.

170

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 903 Harlem Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. G. G. Dudley

(Residence in Baltimore: No. 903 Harlem Ave St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Married

6-DATE OF BIRTH, Dec. 5, 1864 (Month) (Day) (Year)

7-AGE, 56 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 066
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, W. C. Dudley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Anna Bailey

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss M. A. Dudley

(Address) Mercy Hospital

15- Robert P. Harrison,

Filed NOV 12 1921, 191.... Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Diffu. Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) and Epilepsy

(Duration) yrs. mos. ds.

(Signed) J. H. Hannikan M. D. (Coroner.)

Nov. 11, 1921. (Address) 2802 Edgemont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 12, 1921
20-UNDERTAKER	ADDRESS
John O'Mulvihill	1211 E. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

(See affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58511

CERTIFICATE OF DEATH.

X 109 D 58511

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan V. Weller. H.SW. Susan Jemima Walker

(Residence in Baltimore: No. Franklin Square Hospital St.; yrs., mos. 7 ds.) Crumpton Md.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 15, 1847 (Month) (Day) (Year)

7-AGE, 67 H.SW. 6 H.SW. 18 H.SW. 70 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Carville

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ann Legg

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Harrison

(Address) Crumpton Md

15- Robert P. Harrison

Filed NOV 12 1921, 191..... Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 4 1921, to Nov. 11 1921

that I saw her alive on Nov. 11 1921

and that death occurred, on the date stated above, at 9.00 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Fecal Impaction

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Louis M. Lintz M. D.

Nov. 11, 1921 (Address) Grant & Fayette Sts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 7 ds. In the State 70 yrs. 5 mos. 26 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Crumpton Md

19-PLACE OF BURIAL OR REMOVAL, Crumpton Md — DATE OF BURIAL, Nov. 13, 1921

20-UNDERTAKER John O'Mitchell — ADDRESS 130 W. Fayette St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS LEGAL RECORD.

affidavit made by the daughter of Mrs. Susanne L. V. Wallis, the daughter's name being Mrs. Emma Harrison, the following corrections were made on death Certi icate #D-58511 changing the name to Susanne L. V. Wallis and changing the date of birth to May 24, 1854,

Remarks

Personally appeared before me this 5th day of January, 1922.

H. E. Worlock

Sup't of Franklin Square Hospital

Notary. Reed Smith Paul & Co

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58512 (1318 43)

91 D 58512

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosella Cogdell

(a) RESIDENCE. No. 1523 Jefferson St. St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) North Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Cassie Nash

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Johns Hopkins Hospital
(Address) Records.

15 Filed Nov 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1921, to Nov 9th, 1921, that I last saw h[illegible] alive on Nov 9th, 1921, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Septicemia (Hemolytic Streptococcus)
(Apparently from pneumonia process)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (bilateral)

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Courtes Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington N.C.	Nov 17 1921

20 UNDERTAKER R.B. Gross ADDRESS 1405 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item and mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58513

CERTIFICATE OF DEATH.

D 58513

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1402 Fraction ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence H Towson

(Residence in Baltimore: No. 1402 Fraction St. 72 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 16, 1849. (Month) (Day) (Year)

7-AGE, 29 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Chauffeur 086
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Towson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachael Pratt

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachael Gaeeaway

(Address) 1402 Fraction St.

15-

Filed ....., 191.... Registrar.

NOV 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 9, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Nov 9 1921, that I saw h[illegible] alive on Nov 9 1921, and that death occurred, on the date stated above, at 11:45 m.

The CAUSE OF DEATH* was as follows:
Endocarditis Acute.

(Duration) ..... yrs. One mo. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Stewart M. D.

....., 191.. (Address) 1424 W Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, U.S. National Cemetery

DATE OF BURIAL, Nov. 12, 1921

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Etting St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58514

CERTIFICATE OF DEATH.

D 58514

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 328 S. Dallas ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Lloyd

(a) RESIDENCE. No. 328 S. Dallas ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Lloyd

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 008

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Cora Trusty
(Address) 328 S. Dallas St

15 Filed Robert P. Harrison, Registrar

NOV 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 4 . 1921 . to Nov 9 . 1921 .

that I last saw him alive on Nov 8 . 1921 .

and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

11-9. 1921 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Zion Cemetery	Nov 1921
20 UNDERTAKER	ADDRESS
John H Owens	538 Dolphin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every line must be filled. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58515 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J Ryan

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., Baltimore WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Baltimore Md.

15 Robert P. Hartman, Registrar

NOV 12 1921 , 19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 19 21 to Nov. 10, 19 21.

that I last saw him alive on Nov 10, 19 21.

and that death occurred, on the date stated above, at 8. p.m.

The CAUSE OF DEATH* was as follows: Chronic Cardiac Valvular disease) mitral insufficiency broken compensation.)

Nov. 4, 1921 (duration) -- yrs. -- mos -- ds.

CONTRIBUTORY (Secondary) ---- (duration) --- yrs. --- mos. -- ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

11/10, 19 21 (Address) PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Yorkers N Y

DATE OF BURIAL Nov 12 19 21

20 UNDERTAKER E. Levinson Bro

ADDRESS 1127 E. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58516

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 113 S Greene ST.: 4 WARD)

2-FULL NAME Nastazie Grebleuckene

(a) RESIDENCE. No. 113 S Greene ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of S. Grebleuckas

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER John Zinkevcus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER V. Blavcuht

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant John Zinkevcus (Address) 113 S Greene St.

15 Filed Nov 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921, to Nov. 12, 1921, that I last saw h[illegible] alive on Nov. 11, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. B. Bromwell, M. D.

11-12, 1921 (Address) 615 S Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem,	11/14/21

20 UNDERTAKER ADDRESS

John Grebliauckas 425 S Paca St

MARGIN RESERVED FOR BINDING—N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CERTIFICATE is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

58517 D 58517

HEALTH DEPARTMENT—CITY OF BALTIMORE

58517 | 5 | D 58517

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital ST. WARD)

2-FULL NAME Baby Heatley

(a) RESIDENCE NO. St. Agnes' Hospital WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1 hour

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jas. S. Heatley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lyndenville Md

12 MAIDEN NAME OF MOTHER Anna Brentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Joseph S. Heatley
(Address) Govans Md

15 Filed NOV 13 1921 ROBERT J. KRAUTER Registrar Bertel Powell Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 19 21

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 19 21, to Nov 11, 19 21.

that I last saw h[illegible] alive on Nov 1, 19 21

and that death occurred, on the date stated above, at 10:10 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth
Duration of Pregnancy
4½ months

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. C. Caldwell M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Md	Nov 13 1921
20 UNDERTAKER	ADDRESS
M. Fahey & Sons	1827 W North Ave

58518 D 58518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58518 D 58518

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Hollins St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Clark.

(Residence in Baltimore: No. 1204 Hollins St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 18 (Day), 1859 (Year)

7-AGE, 62 yrs. 6 mos. ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): Locomotive

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas J Clark

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Margaret Primrose

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Clark

(Address) 1005 N. Fremont st

15- [illegible] Registrar.

Filed NOV 13 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5th 1921, to Nov 10th 1921, that I saw h[illegible] alive on Nov 10th 1921, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

General Bilateral Paralysis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Injury from falling down stairs (Duration) ....yrs. ....mos. 5 ds.

(Signed) Howard Leland M. D.

Nov 11th 1921. (Address) 301 Maxwell Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Nov. 14., 1921

20-UNDERTAKER Robert Brooks & Son — ADDRESS S. E. Cor Calhoun & Hollins st

Spec.—6-9-19—H. P. Co.—100.

58519

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D 58519

58519 D 58519

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice Point

(a) RESIDENCE. No. 229 North Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Joseph Point

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General natnre of Industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Zefel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER A. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Robert Brooks (Address) 178 Calhoun St

15 Filed NOV 13 1921 ROBERT J. BROOKS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1921 to Nov. 12, 1921, that I last saw her alive on Nov. 12, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation 1 day

adult pleurisy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) John H. Elton, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Nov 15 1921

20 UNDERTAKER: Robert Brooks & Son

ADDRESS S. E. Cor Calhoun & Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Edgar Jackson ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58520

CERTIFICATE OF DEATH.

110 D 58520

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2331 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edd Jackson

(a) RESIDENCE. No. 2331 Division St WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Jackson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Geo Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annetta [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Celia Jackson (Address) 2331 Division St.

15 Filed NOV 13 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-13, 1921, to 11-10, 1921, that I last saw him alive on 11-10, 1921, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Gastritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Chronic Contractor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. E. Dorr, M. D.

, 19 (Address) 1608 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Masons Wharf Lancaster Co Pa	Nov 13 1921
20 UNDERTAKER James H. Dennis	ADDRESS 1323 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58521

CERTIFICATE OF DEATH.

64 D 58521

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Madison av ST.; 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eli Simons

(Residence in Baltimore: No. 1727 Madison av St.; 21 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate. Exact statement of OCCUPATION is very may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October 7, 1854 (Month) (Day) (Year)

7-AGE, 67 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Clo

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, David Simon

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophie Feldsteimer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Simons

(Address) 1727 Madison ave

15-

Filed NOV 13 1921, 191 ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1921, to Nov 11 1921, that I saw him alive on on Nov 11 1921, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

apoplexy

hemorrhage left brain

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

(Signed) Joseph E Jackson M. D.

Nov 12 1921 (Address) 1576 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship DATE OF BURIAL, Nov. 13, 1921

20-UNDERTAKER J. Ahrens & Co ADDRESS 611 Mad ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58522

CERTIFICATE OF DEATH.

1320 D 58522

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Valley ST., 10 WARD)

2-FULL NAME Ellen Baker

(a) RESIDENCE NO. 1019 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thomas Baker Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Boban

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Magoha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Eugine Widman

(Address) 1017 Valley st

15 Filed NOV 13 1921 ~~BURIAL PERMIT ISSUED~~ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1921.

17 I HEREBY CERTIFY, That I attended deceased from ~~Oct~~ 25, 19 , to Nov 10, 1921, that I last saw her alive on Nov 10, 1921, and that death occurred, on the date stated above, at 1240 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) 4 or 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Coma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? microscopic & chemical

(Signed) Mary F Voeglin ~~xxx~~ M. D.

11.10 1921 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL Nov 14 1921

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D 58523

HEALTH DEPARTMENT—CITY OF BALTIMORE

64-091

D 58523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Savage

(a) RESIDENCE NO. 293 Calhoun Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant J. Lewis (Address) 1411 E. Baltimore St.

15 Filed NOV 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1921 to Nov 12 1921, that I last saw her alive on Nov 1921, and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? /

(Signed) Zinberg, M. D.

11/12, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery DATE OF BURIAL 11-13 1921

20 UNDERTAKER Jack Lewis, ADDRESS 1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58524

CERTIFICATE OF DEATH.

64 D 58524

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 W. Lafayette Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Wolf.

(a) RESIDENCE. NO. 1624 W. Lafayette Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced (or) WIFE of Emma K. Wolf.

6 DATE OF BIRTH (month, day, and year) Dec. 23-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ernest G. Wolf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Augustine Geisler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mary K. Bloemke 1624 W. Lafayette Ave.

15 Filed NOV 13 1921 ROBERT I. GRIFFITH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1921, to Nov 11th, 1921, that I last saw him alive on Nov 11th, 19..., and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) following fall (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock, superinduced by Ruptured Stomach (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Lockard, M. D.

11/12, 19 21 (Address) 703 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL Nov. 14 1921

20 UNDERTAKER Lilly & Son

ADDRESS 403 W. Mulberry St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58525

CERTIFICATE OF DEATH.

113 D 58525

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Greenmount Ave ST.; 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Ada Coll

(Residence in Baltimore: No. 2601 Greenmount Ave St.; 60 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. November 10, 1848 (Month) (Day) (Year)

7-AGE. 73 yrs. 0 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods Store

9-BIRTHPLACE, (State or Country), Fairfax Co. Va.

PARENTS.

10-NAME OF FATHER, Barnett Stewart

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Ann Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis J. Coll

(Address) 2601 Greenmount Ave

15- NOV 13 1921 BUREAU OF VITAL STATISTICS

Filed....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1921, to Nov 11 1921, that I saw her alive on Nov 11 1921, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

.....

.....

Cardiac Failure

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration).....yrs.....mos.....ds.

(Signed) Louis J. Coll M. D.

Nov 11, 1921. (Address) 2601 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral — DATE OF BURIAL. Nov 14, 1921

20-UNDERTAKER C. A. Wiedefeld Jr — ADDRESS 501 E 22 St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168-004 D 58526

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1600 Brevard ST. 14th WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Murray
(Residence in Baltimore: No. 1600 Brevard Ave. St.; 45 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... Dec. 1 (Month) ..... (Day) ..... now, 1861 (Year)

7-AGE, 60 yrs. ..... mos. ..... da.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Grocery Store)

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, James Murray

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Lydia Briscoe

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gertrude Scipio
(Address) 2032 Druid Hill Ave.

15-
Filed NOV 13 1921 19.. REGISTRAR
Registered.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Coal gas, (suicidal)
(Duration) ..... yrs. ..... mos. ..... da.
CONTRIBUTORY (Secondary) Accidental
(Duration) ..... yrs. ..... mos. ..... da.

(Signed) J. T. Hennessey M. D.
(Coroner.)
Nov. 13, 1921 (Address) 202 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem.
DATE OF BURIAL, Nov 15, 1921

20-UNDERTAKER George T. A. Gibson
ADDRESS 513 Fairmount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58527

CERTIFICATE OF DEATH.

45

D 58527

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Municipal Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Copper

(a) RESIDENCE. No. 1622 Calhoun St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Eastern Shore, Maryland

PARENTS

10 NAME OF FATHER: William Copper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Henrietta Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 NOV 13 1921

Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1921 to November 11 1921, that I last saw her alive on November 10, 1921, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/11/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Nov. 14 1921

20 UNDERTAKER: Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58528 ✓ 28 D 58528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE, NO. ..... ST. 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Coleary.

(a) RESIDENCE. NO. Unknown ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 5 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE — Years: 48 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book. Agent.

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Cleary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Nova Scotia

12 MAIDEN NAME OF MOTHER: Annie Meade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cleland.

14 Informant ..... (Address) Bayview Hospital Balto. Md.

NOV 13 1921 ..... Registrar

Bur. of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1921, to Nov. 12, 1921, that I last saw him alive on Nov. 12, 1921 and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Toxic Psychosis.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Fredgmark M. D.

11/14/21 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 11/14/21

20 UNDERTAKER: Chas F. Evans & Son — ADDRESS: 1187 W. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

12-1650 58529

CERTIFICATE OF DEATH.

14 D 58529

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marie Leonard

(a) RESIDENCE. No. 408 N. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-6-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Theresa Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 13 1921 ROBERT I. BRAUN Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1921, to 11-13, 1921, that I last saw h Ch alive on 11-13, 1921, and that death occurred, on the date stated above, at 5:40 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Stool Culture B. Flexner.

(Signed) Horace G. Stewart, M. D.

11/13, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dod Laurel Cem

DATE OF BURIAL: Nov 15th 1921

20 UNDERTAKER: Geo M. Flood & Son

ADDRESS: 811 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58530

CERTIFICATE OF DEATH.

6 175-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Church Home ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Guy Upton

(Residence in Baltimore: No. 2307 E. Fairmount ave St.; yrs., 2yr mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 22 (Day), 1915 (Year)

7-AGE, 6 yrs. 5 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Geo Upton

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Addie Draper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Upton

(Address) 2307 Fairmont

15-

Filed NOV 13 1921 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract skull and internal injuries - struck by automobile accident (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) (Duration) .....yrs.....mos.....ds.

(Signed) H. J. Riley (Coroner.) M. D.

Nov 11, 1921 (Address) 1437 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Nov. 14, 1921

20-UNDERTAKER Wm J Ecknerton

ADDRESS N & Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58531

CERTIFICATE OF DEATH

105 D 58531

REGISTERED NO.

1-PLACE OF DEATH St. Agnes' Hospital

CITY OF BALTIMORE: (No. Baltimore Md ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doctor Frank Paul

(a) RESIDENCE NO. 2401 E. Preston ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov 4 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	33	0	7	

8 OCCUPATION OF DECEASED 054

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Physician

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Witt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. B. Paul

(Address) 2401 E. Preston

15 NOV 13 1921 ROBERT I. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 19 21 to Nov 11 19 21.

that I last saw h[illegible] alive on Nov 11 19 21

and that death occurred, on the date stated above, at 7:10 p. m.

The CAUSE OF DEATH was as follows:

Perforated Duodenal Ulcer—

Not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Peritonitis—

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 11-9-21

Was there an autopsy? No Operation

What test confirmed diagnosis?

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 15 1921
20 UNDERTAKER	ADDRESS
Wm J Dickus & Sons	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58532

CERTIFICATE OF DEATH.

50 D 58532

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20-E-21 St. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Bell Robinson

(a) RESIDENCE NO. 20-E-21 St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M. Robinson

6 DATE OF BIRTH (month, day, and year): Nov 14 1857

7 AGE — Years: 63 Months: 11 Days: 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westminster Md

PARENTS

10 NAME OF FATHER: Geo E Wampler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westminster Md

12 MAIDEN NAME OF MOTHER: Julia Shriver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Croxton

(Address): 20 E 21st

15 Filed NOV 13 1921, 19 ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1924, to Nov 12, 1921, that I last saw her alive on 11 Nov, 1921 and that death occurred, on the date stated above, at 3.00 a m.

The CAUSE OF DEATH* was as follows: Gangrene of Left foot

(duration) Oct 12- to Nov 12 24 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes (duration) yrs. 4 mos. 00 ds.

18 Where was disease contracted if not at place of death? Her home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. B. Gossard, M. D.

11-12-24 19 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md — DATE OF BURIAL: Nov 15, 21

20 UNDERTAKER: Wm Fuchs Sons — ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

JACKSON

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58533
1-PLACE OF DEATH

120 D 58533
REGISTERED NO.

CITY OF BALTIMORE: (No. 1849 W. North ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Jackson

(a) RESIDENCE NO. 1849 W. North ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ (HUSBAND) of (or) WIFE of Andrew Jackson

6 DATE OF BIRTH (month, day, and year) Jan 3, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	69	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER R. L. Liggon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales (?)

12 MAIDEN NAME OF MOTHER Susan Cogswell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant McPherson Fillis
(Address) 1849 W North Ave

15 Filed NOV 13 1921 ROBERT J. KRAUTER Registrar
Burial Permit 01668

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1921, to Nov 11, 1921, that I last saw her alive on Nov 10, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis, Chronic nephritis & Cardiac insufficiency

about 4
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Coma & delerium
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no minus in me

What test confirmed diagnosis?

(Signed) W. E. Knuff, M. D.

1921 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Nov 14 1921
20 UNDERTAKER Wm J. Pickett & Son	ADDRESS North Ave & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58534

154 D 58534

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1300 Wheeling ton ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leander Bond

(a) RESIDENCE No 1308 Wheeling ton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18" 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	87	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick mason

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer Your Boss Co.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Howard H Kreitz

(Address) 3814 Keswick Ave

15 NOV 13 1921 ROBERT I KRAUTER Registrar of Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 19 21

17

I HEREBY CERTIFY, That I attended deceased from Nov 8, 19 21, to Nov 11, 19 21,

that I last saw him alive on Nov 10, 19 21

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Softening Sclerosis

duration by Dr

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.

11-14, 19 21 (Address) 607 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	11/14/21
20 UNDERTAKER	ADDRESS
W J Sidmon Sons	Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58535

REGISTERED NO. 15-79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1673 W. North Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Henrietta Prather

(a) RESIDENCE. NO. 1673 W. North Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Oliver Prather

6 DATE OF BIRTH (month, day, and year) Mar 25th, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cedar Grove Md

PARENTS

10 NAME OF FATHER Wm Yewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta Weedon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Yewell E. Prather

(Address) 1673 W. North Ave

15 Filed NOV 14 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8 , 1921 , to Nov. 11 , 1921 .

that I last saw h alive on Nov. 11 , 1921 .

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Emphysema

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Sindin McElwee , M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 14 1921

20 UNDERTAKER Bertram L. Goe ADDRESS 1723 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Valvular Disease of Heart

Spec.—1-10-21—M&T—1500 Blks.

D58536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 D 58536

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 Druid Hill Ave ST., WARD)

2-FULL NAME Mrs. H. Adams

(a) RESIDENCE NO. 1328 Druid Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary Adams

6 DATE OF BIRTH (month, day, and year) Unknown 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) — 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pattonsville Md

PARENTS

10 NAME OF FATHER Lewis Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Nathan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Harris

(Address) 1328 Druid Hill ave

15 Filed NOV 14 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/12/1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1921, to Nov. 12, 1921, that I last saw h alive on Nov. 11, 1921, and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Uremia (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis (Duration) 1 yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Toppin M. D.

(Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Starland	Nov 13 1921
20 UNDERTAKER David D Hensley	ADDRESS 578 N Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 58537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 58537

REGISTERED No. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1825 - Gaupor ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Grover R Brown

(Residence in Baltimore: No. 1825 - Gaupor St.; yrs. 5 5 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Feb 28, 1866 (Month) (Day) (Year)

7-AGE: 5 5 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer): 804

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER: A. Brown

11-BIRTHPLACE OF FATHER (State or Country): England

12-MAIDEN NAME OF MOTHER: — Purnell

13-BIRTHPLACE OF MOTHER (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Brown

(Address) 1825 Gaupor

15-

Filed NOV 14 1921, 191.... [illegible] Registrar.

Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Contributory) (Duration) yrs. mos. ds.

Bed sore

(Secondary) (Duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner.)

Nov 14, 1921. (Address) 165 7 Eu

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cem

DATE OF BURIAL: Nov 15, 1921

20-UNDERTAKER: W M Routson

ADDRESS: 223 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58538

CERTIFICATE OF DEATH.

53 D 58538

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. McCauley

(a) RESIDENCE. NO. 117 N. Bond St. (Bonaparte St.) ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth McCauley

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D.C.

PARENTS

10 NAME OF FATHER Wm. McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Virginia Leyton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

Filed NOV 14 1921 [illegible] Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1921. 15 to Nov 13, 1921. that I last saw him alive on Nov. 13, 1921. and that death occurred, on the date stated above, at 9:35 a.m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Excision & exam of gland

(Signed) C. C. Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 16 1921
20 UNDERTAKER J. M. Routson	ADDRESS 2301 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58539

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Schell

(a) RESIDENCE. No. 2019 Wilhelm St, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) Municipal Hospital.

15 NOV 14 1921 ROBERT J. BRAUTIGAM Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15 1914 to Nov. 11 1921. that I last saw h alive on November 11 1921. and that death occurred, on the date stated above, at 11:05 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Clyde M. Cuille, M. D.

11/12/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Nov 14 1921

20 UNDERTAKER F. B. Hippert ADDRESS 2256 Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58540

CERTIFICATE OF DEATH.

10-089

10 D 58540

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 Wolfsens Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores Mary Hartmann

(a) RESIDENCE. (Usual place of abode) No. 2422 Wolfsens Ave ST. 20 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 15-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Paul Hartmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Stella Hammerstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cato Md.

14 Informant Paul Hartmann (Address) 2422 Wolfsens Ave

15 Filed NOV 14 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-10-21, 1921, to 11-12, 1921.

that I last saw her alive on 11-12, 1921.

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Infection of Tonsils

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) acute Bronchitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Asa L Wolfsells, M. D.

(Address) 2276 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Nov 16 1921

20 UNDERTAKER H B Nippert

ADDRESS 2236 Fred'k Ave

N. B.—WRITE PLAINLY. WITH LEAD PENCIL. All items must be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Staphlococcic infection. Not diphtheretic

No pneumonia

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58541

CERTIFICATE OF DEATH.

D 58541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 934 Harford ave ST.: 10 WARD)

2-FULL NAME Angelina Colaianni

(a) RESIDENCE. NO. 934 Harford ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21-1896

7 AGE 24 Years 11 Months 22 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Giuseppe Colaianni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmela Lommi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Giuseppe Colaianni
(Address) 934 Harford ave

15 Filed NOV 14 1921 ROBERT I. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13- 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov-10th. 1921, to Nov 13, 1921, that I last saw h[illegible] alive on Nov -13, 1921, and that death occurred, on the date stated above, at 1. A. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis.

(duration) yrs. 2. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no Knowledge

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical diagnosis

(Signed) Thos. H. Mogrus, M. D.

, 19 (Address) 14. East Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 11/15 19 21

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford ave

N. B.—WRITE PLAINLY. WITH CAPS AND SMALL LETTERS. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58542

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Dept ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David A. Peck

(a) RESIDENCE. No. 405 Cedar Croft Road ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella L. Peck

6 DATE OF BIRTH (month, day, and year): Oct 26 1837

7 AGE — Years: 84 — Months: 8 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Paymaster

(b) General nature of industry, business, or establishment in which employed (or employer): B&O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Stephen Peck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Bluford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Nellie Peck Cuttle 5901 York Road

15 [illegible] NOV 14 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 17th Nov 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 29th, 1921, to Nov 17th, 1921, that I last saw h. alive on Nov 17, 1921, and that death occurred, on the date stated above, at 11.05 P.M.

The CAUSE OF DEATH* was as follows:

Fracture Left Femur

(Coma)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ruth E. Rice, M. D.

, 19 (Address) Church Home & Inf. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: Nov. 15 192[illegible]

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

N. B.—WRITE PLAINLY. WITH LEAD PENCIL OR PEN AND INK. AGE should be stated EXACTLY. PHYSICIANS should state nation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58543

CERTIFICATE OF DEATH.

D 58543

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 901 N. Fulton ave- ST., 16 WARD)

2-FULL NAME Georgie Oliver Flack

(a) RESIDENCE NO. 901 N. Fulton ave- ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	7	29	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work ..... not any

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) Balto -
(State or country) md

PARENTS

10 NAME OF FATHER James W. Flack

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Baker

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md-

14 Informant Susie B. Flack —
(Address) 901 N. Fulton ave-

Filed NOV 14 1921 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Nov 12, 1921,

that I last saw her alive on Nov 10, 1921

and that death occurred, on the date stated above, at 2.50 - P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Several (duration 2+ yrs.) mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) Wm J. Walsh M. D.

19 21 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL Nov 14 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1251 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58544

CERTIFICATE OF DEATH.

91-069

D 58544

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 512 N Bradford ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Swift

(a) RESIDENCE. No. 512 N. Bradford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Sydney Swift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Springfield Ohio

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Sydney Swift 512 N Bradford

15 Filed NOV 14 1921 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1921, to Nov. 11, 1921, that I last saw h[illegible] alive on Nov 11, 1921, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

(duration) yrs. - mos. 2 ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

19 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery Nov	14 1921
20 UNDERTAKER	ADDRESS
James. M. Skinner	1625 E Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state AGE EXACTLY. mation should be carefully supplied. Exact statement of OCCUPA-CAUSE OF DEATH should be properly classified. TION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Queen & Crapeticus

61 ✓ D 58545

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No 24 Worrell Inf Winans 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edmund D. Christian

(Residence in Baltimore: No. 24 Worrell St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Cold

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 2 (Month) 24, (Day) 1921 (Year)

7 AGE ..... yrs. 6 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER William H Christian

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Arabella Hill

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H Christian

(Address) Inf Winans

15 FILED NOV 14 1921 BOARD OF HEALTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 (Month) 12 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-7-, 1921, to 11-12, 1921, that I saw h~~im~~ alive on 11-12, 1921, and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... yrs. ..... mos. 5 ds

Contributory (SECONDARY) Otitis media suppurativa

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Black M. D.

11-13-, 1921 (Address) Walbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Mt Auburn

DATE OF BURIAL Nov 15, 1921

20 UNDERTAKER Edward Ringgold

ADDRESS 1463 N Caren

Simple meningitis. No other abnormal condition known to doctor.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58546

CERTIFICATE OF DEATH.

104 D 58546

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE (No. 1401 Division St. ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Dawson

(a) RESIDENCE. NO. 1401 Division St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Dawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant St Vincents (Address) 1401 Division St

15 Filed NOV 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 11, 1921, that I last saw her alive on Nov 11, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Claudius M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 14 1921
20 UNDERTAKER	ADDRESS
Martyn Fahey & Sons	1827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58547.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 58547

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bullock

(a) RESIDENCE. NO. None ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed NOV 14 1921 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from November 5, 1921, to November 8, 1921, that I last saw him alive on November 8, 1921, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 (?) mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

8/9/. 1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS NOV 12 1921

JOHNS HOPKINS HOSPITAL

Commissioner Health.

Dr. Wm. H. WOOLAN

S. E.—WRITE PLAINLY. All questions must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58548 CERTIFICATE OF DEATH. 56 D 58548

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Duvall

(a) RESIDENCE. No. 16 S Bethel St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER George Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington, D.C.

12 MAIDEN NAME OF MOTHER Sally Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington, D.C.

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed . 19 NOV 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1921

17

I HEREBY CERTIFY, That I attended deceased from October 29, 1921, to November 9, 1921, that I last saw h. alive on November 9, 1921, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Chronic alcoholism; neuro-
tales peripherica; optic atrophy;
acute enteritis; Vincents angina.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

11/9/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. McNeil gives the Alcoholism as the Primary no Syphilis or Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58549

CERTIFICATE OF DEATH.

D 58549

1-PLACE OF DEATH (No. Municipal Tuberculosis Hospital ST. 5 WARD)

CITY OF BALTIMORE

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Johnson

(a) RESIDENCE. NO. 1117 McElderry st. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER Helen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address): Hospital Records M.T.H.

15 NOV 14 1921 ROBERT A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1921, to Nov. 9, 1921, that I last saw him alive on Nov. 9, 1921, and that death occurred, on the date stated above, at 10.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Balaglucci M. D.

11-9-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER: Commissioner Health.	ADDRESS NOV 1 1921

By WM. F. WOODALL

N. B.—WRITE PLAINLY, WITH LINK AND PEN. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58550

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Tyler

(a) RESIDENCE. NO. 1237 E. Madison St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington, D.C.

PARENTS

10 NAME OF FATHER: William H. Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington, D.C.

14 Informant (Address): Hospital Records, Municipal Hospital.

15 NOV 14 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9, 19 21

17 I HEREBY CERTIFY, That I attended deceased from November 7, 1921, to November 9, 1921, that I last saw him alive on November 9, 1921, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Mill, M. D.

11/10/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS
Commissioner Health	NOV 12 1921

N. B.—WRITE PLAINLY. WHERE PRINTED INFORMATION IS REQUIRED, STATE EXACTLY. PHYSICIANS should state mation should be carefully considered. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58551

CERTIFICATE OF DEATH.

79 ✓ D 58551 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2106 W Mulberry ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia D Hall

(a) RESIDENCE. NO. 2106 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Charles A. Hall.

6 DATE OF BIRTH (month, day, and year) July 2, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Accomac C H Va

PARENTS

10 NAME OF FATHER John Milliner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maud Milliner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wilford E Hall

(Address) 512 N. Pulaski St

15 Filed NOV 14 1921 ROBERT J. [illegible] Registrar

Burial Permit Given

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. OCCUPATION mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Nov 11, 1921, that I last saw her alive on Nov 11, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Aortic Stenosis
unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. C. Conser, M. D.

11/12, 1921 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Accomac Va.	Nov 15 1921
20 UNDERTAKER George J Smith	ADDRESS Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58552 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1900 ✓

D 58552
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Aged of the M E St. 2nd Dist. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Dean

(a) RESIDENCE. No. Fulton Ave and Franklin St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Cecil County Md

PARENTS

10 NAME OF FATHER Richard Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Hanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co. Md.

14 Informant Helen E. Bennett
(Address) 400 W. Fulton Av

15 Filed NOV 14 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Nov 13, 1921, that I last saw h[illegible] alive on Nov. 11th, 1921, and that death occurred, on the date stated above, at 7-20 p m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic
(duration) 4 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Pericarditis
(duration) ✓ yrs. 6 mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. C. Shannon, M. D.

11/14. 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 15 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 W. Fayette.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58553.

D 58553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 400 N. Fulton ave ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Perin

(a) RESIDENCE. No. Home for the Aged of the M. E. church ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21 - 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Brooks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Amy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Etta Lindsay

(Address) 400 N. Fulton ave

15 Filed NOV 14 1921 ROBERT J. CRAIG Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 13, 1921, to Nov 12, 1921, that I last saw h[er] alive on Nov 11, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Cathamon, M. D.

11/14, 1921 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 15 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 W. Fayette st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Linden & Laurel Sts (Mt Nemours) ST.; 25 WARD) 179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Niedenmeyer

(a) RESIDENCE. NO. Mt Nemours ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Henry Niedenmeyer

6 DATE OF BIRTH (month, day, and year) Aug 27 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. John Meyer (Address) Mt Nemours Ave.

15 NOV 14 1921 MOLLY S KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 05 1921 to Nov 11 1921 that I last saw her alive on Nov 8 1921 and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Raymond Gibson M. D.

1921 (Address) Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	11-14 1921
20 UNDERTAKER	ADDRESS
Mrs Chas A G Rohde	421 Darlington Ave

mation should be carefully supplied. Age CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58555 — REGISTERED NO. C 81 D 58555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Callow Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Schaefer

(Residence in Baltimore: No. 2400 Callow Ave St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, July (Month) 24 (Day), 1830 (Year)

7-AGE, 91 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Conrad Schaefer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mrs Kuhn

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Schaefer

(Address) 2400 Callow Ave

15 NOV 14 1921 ROBERT J. CRAWFORD Registrar

Filed....., 191.....

Burial Permit Required.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1921, to Nov 13 1921, that I saw him alive on Nov 12 1921, and that death occurred, on the date stated above, at 5.45 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cystitis

Arteriosclerosis (Duration) yrs. 8 mos. ds.

(Signed) John H. Schaefer M. D.

Nov 13, 1921. (Address) 1113 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, David Hill M. Cem. DATE OF BURIAL, 11 15, 1921

20-UNDERTAKER Mrs Chas A G Rohde ADDRESS Pilligon Ave

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

No terminal hemorrhage. No chronic organic heart disease. No history of any other abnormal condition.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 58556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. 91 St.: V Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constance Burke

(a) RESIDENCE. No. 306 S. Chester St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-29-21

7 AGE — Years: — Months: 9 Days: 15 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Tim Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Lillie Lantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: JOHNS HOPKINS HOSPITAL.

(Address)

NOV 14 1921

Registrar

Deputy Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-13, 1921, to 11-13, 1921, that I last saw h[illegible] alive on 11-13, 1921, and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Horace J. Stewart, M. D.

11/13, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 14 1921
20 UNDERTAKER	ADDRESS
John Maderer	1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58557

D 58557

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 78 D 58557

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, Phipps Clinic WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Holt

(a) RESIDENCE NO. Apt 572 Charleston Apt ST., Washington D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mrs. Philip Holt

6 DATE OF BIRTH (month, day, and year) Sept 22 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Naval Service

(c) Name of employer U.S. Government

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER C. H. Holt

11 BIRTHPLACE OF FATHER (city or town) Grand Rapids (State or country) Michigan

12 MAIDEN NAME OF MOTHER Alma Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) Johns Hopkins Hospital

15 Filed NOV 14 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to Nov 12, 1921, that I last saw him alive on Nov. 12, 1921, and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Epilepsy (

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leslie B. Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grand Rapids, Michigan	Nov 14 1921

20 UNDERTAKER H. E. Hughes ADDRESS 4th & Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be carefully supplied. AGE, should be stated EXACTLY. mation should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58558

D 58558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST.: 5 WARD)

REGISTERED No. C - 175

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Bass.

(Residence in Baltimore: No. 130 Aisquith St. 35 St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower

6-DATE OF BIRTH, September 15th. 1842, 1 (Month) (Day) (Year)

7-AGE, 79 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Presser
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Paul Bass.

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Cecelia Katz.

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon J. Bass. (son)

(Address) 637 W. Fayette St.

NOV 14 1921

Filed ....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion of the head and chest
Accidentally struck by car 1939
of U. Ry. & E. Co.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia.

(Duration) ....yrs....mos....ds.

(Signed) Chas. Kennedy M. D. (Coroner)

Nov. 14th, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Lebanon,	11-14-, 19.21

20-UNDERTAKER Jack Lewis, ADDRESS 1411 E. Balto.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58559

CERTIFICATE OF DEATH.

D 58559
1-PLACE OF DEATH

REGISTERED NO. 120

CITY OF BALTIMORE: (No. 320 N. Monroe ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Nitzdorff

(a) RESIDENCE. No. 320 N Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tobias S. Nitzdorff

6 DATE OF BIRTH (month, day, and year) Jan 1 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Penna

PARENTS
10 NAME OF FATHER David Everhart
11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Md
12 MAIDEN NAME OF MOTHER Nancy Stoke
13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Penna

14 Informant Mrs Charles L. Zeber
(Address) 1916 Mt. Royal Terrace

15 NOV 14 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1921, to Nov 13, 1921, that I last saw her alive on Nov 13, 1921, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
about 2 yrs.
(duration)

CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis &c.

(Signed) H. E. Knight, M. D.

Nov. 14 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov 15 1921

20 UNDERTAKER ADDRESS
Chas. J. Black 742 W North ave

N. B.—WRITE PLAINLY WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58560

D 58560

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hamilton

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Henry Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records, Municipal Hospital.

15 Filed NOV 14 1921, 19

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1921 to Nov. 11, 1921, that I last saw him alive on November 11, 1921, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Neill, M. D.

11/12/21 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 1 192

Commissioner Health.

S. B.—WRITE PLAINLY, with ink. Every question on this certificate should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58561

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 S. Robinson ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kally

(a) RESIDENCE. NO. 1117 S. Robinson ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kally.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 073

(b) General nature of industry, business, or establishment in which employed (or employer): Penn. R.R.

(c) Name of employer: Employe.

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Kally
(Address): 1117 S. Robinson St.

15 Filed: NOV 14 1921 19.. Registrar

BOARD OF HEALTH
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Nov 13, 1921, that I last saw him alive on Nov - 10, 1921, and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease
(mitral & aortic insufficy
unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated heart
(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

11/9, 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Nov. 16 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler.	4038 Wolfe

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIANS should state. mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58562

CERTIFICATE OF DEATH.

D 58562

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 376 S. Bouldin St.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Kellner

(a) RESIDENCE NO. 376 S. Bouldin ST., 26 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Kellner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Hamelbacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Anna F. Schweiger
(Address) 377 S. Clinton St.

15 Filed NOV 14 1921 ROBERT I. FOSTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Nov 11, 1921, that I last saw h in alive on Nov 10, 1921, and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

11/13/21 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Nov. 14 1921
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Mt. St.

N. B.—WRITE PLAINLY WITH INDELIBLE PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Margaret Wolters

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58563 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10? D 58563

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St Josephs Hosp ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Wolters

(a) RESIDENCE. No. 2922 W. Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced (or) WIFE of Henry L. Wolters

6 DATE OF BIRTH (month, day, and year) - - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housk. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Mick Eiser

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Mary Eiser

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Catherine Eiser

(Address) 2922 Mosher St.

15 NOV 14 1921 BUREAU OF VITAL STATISTICS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11th 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1921, to Nov. 11, 1921, that I last saw her alive on Nov. 11, 1921, and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

8 days

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Abortion, Acute appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov. 8, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D'Conte, Jr. M. D.

19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/15 1921
20 UNDERTAKER J. F. Talley & Sons	ADDRESS 1211 Light St

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS ... be stated EXACTLY. AGE should be carefully supplied. AGE should be stated in years, months and days. If LESS than 1 day, hours or minutes should be given. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58564

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 505 E. 22nd St. WARD) 19 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Rachine F. Brown

(Residence in Baltimore: No. 505 E. 22nd, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Wt

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Sgle

6-DATE OF BIRTH, Nov (Month) 21 (Day), 1897 (Year)

7-AGE. 24 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER: Robt P Brown

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER: Mary A Conry

13-BIRTHPLACE OF MOTHER (State or Country): Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A Brown

(Address) 505 E 22 St

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

NOV 14 1921, 191

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 13 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Pulmonary

Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Conley M. D.

(Coroner.)

11-13, 191 (Address) W. E. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 16, 1921

20-UNDERTAKER C. A. Weedfield Jr. — ADDRESS 501 E 22 St

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58565

CERTIFICATE OF DEATH.

48

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 E Oliver ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas H Kercher

(a) RESIDENCE. No. 2631 E Oliver ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Anthony Kercher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Genevieve Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Genevieve Kercher
(Address) 2631 E Oliver

15 Filed NOV 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 17 1921, to Nov 12 1921,
that I last saw h alive on Nov 12 1921,
and that death occurred, on the date stated above, at 12 15 P. m.
The CAUSE OF DEATH* was as follows:

Acute Rheumatic Arthritis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis. Myocarditis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. C. Ellicott M. D.

Nov. 19 1921 (Address) 4 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 15 1921
20 UNDERTAKER	ADDRESS
Robt Tolmus Jr	1472 N. Bway.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1006 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58566

D 58566

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Covington St. ST.: 24 WARD)

2-FULL NAME Mary J. Sewell

(a) RESIDENCE. No. 1514 Covington St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Sewell

6 DATE OF BIRTH (month, day, and year) Feb. 28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

137

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas O'Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie O'Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) John H. Sewell 1514 Covington

15 Filed 19 Robert P. Harrison, Registrar

V 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept — 1920, to Nov. 12 1921.

that I last saw her alive on Nov 12 1921.

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Edward J. Wolk, M. D.

19 (Address) 821 N Patterson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St New Cathedral Cem.

DATE OF BURIAL: 11/15 1921

20 UNDERTAKER: S. Fun McEnally

ADDRESS: 130 E. Fay.

GIVE INFORMATION REQUESTED UNDER EACH HEADING. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIAN should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58567

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 Plum Al. ST. 25 WARD)

2-FULL NAME Henry Jarvis

(a) RESIDENCE. NO. 927 Plum Al ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Fisher Jarvis

6 DATE OF BIRTH (month, day, and year) [illegible] 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	—	—	

8 OCCUPATION OF DECEASED 640

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber yard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Rosa Fisher Jarvis 927 Plum Alley

15 Filed NOV 14 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1921, to Nov 11, 1921, that I last saw him alive on Nov 11, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Abs

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Jones M. D.

Nov 14 1921 (Address) 712 S. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 15 1921
20 UNDERTAKER John H. Fradin	ADDRESS 14 W Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58568

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2875 Woodbrook St. 13 WARD)

2-FULL NAME Addie Lee Pelton

(a) RESIDENCE NO. 2875 Woodbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Pelton

6 DATE OF BIRTH (month, day, and year): Dec 7, 1854

7 AGE — Years: 66 — Months: 11 — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country): Baltimore Ohio

PARENTS

10 NAME OF FATHER: John Rutherford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Belle Peterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant (Address): Mrs Belle Whitaker 2875 Woodbrook Ave

15 Filed 19 Registrar: Robert F. Harrison

Burial Permit Clerk

NOV 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 1921

11 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Nov 12, 1921,

that I last saw her alive on Nov 12, 1921

and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Interstitial Nephritis

(duration) one yrs. — mos — ds.

CONTRIBUTORY (Secondary): Anasarca & Pulmonary Oedema

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & symptoms

(Signed) C. H. McElfresh, M. D.

1921 (Address) 1415 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md — DATE OF BURIAL: Nov 15 1921

20 UNDERTAKER: Wm J. Tuckerton — ADDRESS: N. & Pa.

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that all information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Schisler) 15 VD 58569

D 58569 HEALTH DEPARTMENT—CITY OF BALTIMORE VD 58569

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Rosalie av near Harford Road ST. 27 (WARD) Parkville

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Schlesler

(Residence in Baltimore: No. Rosalie av near Harford Road Parkville St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Wht	Bab

6-DATE OF BIRTH, nov 10, 1921 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 3 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... (0)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John J. Schisler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah B. Maul

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Schisler

(Address) Parkville Md.

15- NOV 14 1921 Robert F. Harrison, 191... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, nov 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Josephs Cemetery	Nov. 15, 1921
20-UNDERTAKER	ADDRESS
Frieth Lassahn & Sons	Halleton Md

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58570 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58570

1-PLACE OF DEATH Fulton and Penrose Ave's

CITY OF BALTIMORE (No. Christian Temple Church St.: 19 Ward) REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arnetta C. Amos

(Residence in Baltimore: No. 1831 West Lombard St St.; yrs. 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, December 26th, 1851
(Month) (Day) (Year)

7-AGE, 69 yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Robert Nappier

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Frances Rippley

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Max Kruemmel

(Address) 1831 West Lombard St.

15- Robert F. Harrison,

Nov 14, 191.... Burial Permit Clerk, Registrar.

NOV 14 1921

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. Bladel M. D.
(Coroner.)

Nov 13 1921 (Address) 143 No. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery DATE OF BURIAL, Nov 15, 1921

20-UNDERTAKER Joseph P. Cook ADDRESS 1003 N. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58571
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1242 Hargrett Lane ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Eleanor Fanton

(a) RESIDENCE. No. 1242 Hargrett Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, ~~Married, Widowed,~~ or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	8	26	

8 OCCUPATION OF DECEASED —
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry N. Fanton
11 BIRTHPLACE OF FATHER (city or town) (State or country) York, Pa.
12 MAIDEN NAME OF MOTHER Ruth E. Day
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry N. Fanton
(Address) 1242 Hargrett Lane

15 Filed NOV 15 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Nov 14, 1921, that I last saw h[illegible] alive on Nov 13 - 1921, and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever - Nephritis

(duration) — yrs. 5 mos. 28 ds.

CONTRIBUTORY (Secondary) Nephritis Convulsions

(duration) — yrs. — mos. 20 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W. G. Cappage, M. D.

Nov. 14 1921 (Address) 2303 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 15 21
20 UNDERTAKER	ADDRESS
George F. Ruth.	1735 Hayford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58572

CERTIFICATE OF DEATH.

50 D 58572

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 Schaffer ave ST. Hamilton 27 WARD)

2-FULL NAME Louisa Hucht.

(a) RESIDENCE. No. 16 Schaffer ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~ (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Late Louisa Hucht.

6 DATE OF BIRTH (month, day, and year): August 15th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60		2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Groed.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant Mr. J. Emory. (Address) 1016 Schaffer Ave

15 Filed . 19 [illegible] Registrar

NOV 15 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 1921.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to Nov 14, 1921, that I last saw h[illegible] alive on Nov 14, 1921, and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Diabetis Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Fehlings

(Signed) Chas Smith, M. D.

11/14 1921 (Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 17 1921

20 UNDERTAKER: George J. Rutter ADDRESS 1735 Hayfield ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58573

CERTIFICATE OF DEATH.

64

D 58573

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 216 N: Collington Ave (St.) 6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggaret B: Hofferbert

(a) RESIDENCE. NO. 216 N: Collington Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Hofferbert

6 DATE OF BIRTH (month, day, and year) May 24th 1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	5	I7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Hofferbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jane Hepps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm F: Miller
(Address) 816 N. Collington Ave

15 Filed NOV 15 1921 19 ROBT. F. STRICKER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 7th, 19 21 Nov 12 19 21, that I last saw h[illegible] alive on Nov 12 19 21, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Thy. E. C. Eades, M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem

DATE OF BURIAL Nov 15 1921

20 UNDERTAKER J Deems & Co

ADDRESS Woodberry

Should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58574

CERTIFICATE OF DEATH.

64 D 58574

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 S. 5th St ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna A. Heikel.

(a) RESIDENCE. NO. 230 s: 5th St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Heikel

6 DATE OF BIRTH (month, day, and year): Nov 15th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Fredk Schier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Knight (Knight)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs J: Duchacek

(Address) 230 S. 5th St

15 NOV 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1918 to Nov 1921, that I last saw her alive on Nov 12 1921, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Signs

(Signed) W. B. Arnold, M. D.

Nov 14, 1921 (Address) 109 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: Nov 16 1921

20 UNDERTAKER: J Kervizo Co — ADDRESS: 2008 Eutaw

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58575 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58575

CERTIFICATE OF DEATH. 165

1-PLACE OF DEATH John Hopkins Hosp Registered No. C

CITY OF BALTIMORE (No. 1 Marine Factory ST.: 6 WARD)

2-FULL NAME Annie Faulkner

(Residence in Baltimore: No. 3422 N. Bethel St.; 4 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, Col. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 4 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Geo Faulkner

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER C. Cudley

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Brooks

(Address) 42 N. Bethel

15- Filed NOV 15 1921 19.. Registrar. [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11 17, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
Lobar infiltration in upper lung
4 days (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Nephritis
(Duration) yrs. mos. ds.
(Signed) W F Daly M. D.
(Coroner)
Nov 14, 1921 (Address) 16 39 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 4 yrs. 1 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenlawn, N. C. DATE OF BURIAL, Nov 15. 1921

20-UNDERTAKER John W Henderson ADDRESS 1503 E Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58576

D 58576

CERTIFICATE OF DEATH.

91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 771 Bradley St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nolle A. Thomas

(Residence in Baltimore: No. 771 Bradley St., St. ...yrs., 8 mos. 6 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, March (Month) 8 (Day), 1920 (Year)

7-AGE, ...yrs. 8 mos. 6 da.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 500

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Nolle Thomas

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Maggie Saunders

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nolle Thomas

(Address) 771 Bradley St.

15- NOV 15 1921 REGISTRAR

Filed ..... 191.....

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ...yrs. ...mos. 2 da.

CONTRIBUTORY (Secondary) ~~and Cystitis~~

(Duration) ...yrs. ...mos. ...da.

(Signed) J. T. Hennessy M. D. (Coroner.)

Nov. 14, 1921 (Address) 2802 Eutaw Place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...da. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. | DATE OF BURIAL, 11/16/21 19...

20-UNDERTAKER Theodore White | ADDRESS 1138 W. Fay. Pl.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNER

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58577

D 58577

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 911 Parish St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Warner

(a) RESIDENCE. No. 911 N. Parish ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boot Black

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Clara A. Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Maggie Warner
(Address) 911 Parrish

15 NOV 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 19 21, to 11/13, 19 21,
that I last saw h[illegible] alive on 11/13, 19 21,
and that death occurred, on the date stated above, at 3:25 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bm Roth, M. D.

11-14, 1921 (Address) 2 W. Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Nov 15 1921

20 UNDERTAKER: Sam'l H. Chase & Son — ADDRESS: 1400 Mosher

mation should be carefully examined. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58578

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 58578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 Oakley. ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Young

(a) RESIDENCE. No. 2003 Oakley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sarah L. Young

6 DATE OF BIRTH (month, day, and year) Apr. 29. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paver. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll County Md.

PARENTS

10 NAME OF FATHER David Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md.

12 MAIDEN NAME OF MOTHER Elizabeth Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md.

14 Informant Sarah L. Young (Address) 2003 Oakley St

15 NOV 15 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12 1921, to Nov 14 1921, that I last saw him alive on Nov 14 1921, and that death occurred, on the date stated above, at 11.06p m.

The CAUSE OF DEATH* was as follows:

Paralysis Right Paraplegia

(duration) ? yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis.

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo A Shannon, M. D.

11/15 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rocky Hill Frederick Co Md	Nov. 17. 1921
20 UNDERTAKER George J. Smith.	ADDRESS 1000 N. Fayette St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58579 (2) ✓ D 58579

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Cohen.

(a) RESIDENCE. No. 204 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/13/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Benjamin Cohen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Goldie Schreuer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant
(Address)

15 NOV 15 1921 ROBERT J. BRUTON Registrar
Burial Permit 6102

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15/21

17

I HEREBY CERTIFY, That I attended deceased from 11/10/21 8:35 a.m., 19 21, to 11/15/21 4:45 a.m. 19 21,
that I last saw h alive on 11/15/21 2 p.m., 19 21,
and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

"Premature Birth".
Labor was induced on acct of
contracted pelvis - preg nancy four
8 months (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/10/21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Julius Goldzieher. M. D.
19 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carnegie Colonatory.	19
20 UNDERTAKER	ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58580

CERTIFICATE OF DEATH.

151 D 58580

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 342 S 13th ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wm J Craig Jr

(Residence in Baltimore: No. 342 S 13th St

St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 11, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm J Craig Senior

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Margaret Temple

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J Craig Senior

(Address) 342 S 13th St

15-

NOV 15 1921 191... [signature] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.
(Coroner.)

Nov 15, 1921 (Address) 1600 N Arlington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Nov 16, 1921
20-UNDERTAKER Philip Henry	ADDRESS 2016 Aisquith

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58581

CERTIFICATE OF DEATH.

130 D 58581

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2252 Linden ave St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Spandauer

(Residence in Baltimore: No. 2252 Linden Ave St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 18, (Month) (Day) 1871 (Year)

7-AGE, 50 yrs. 5 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dress Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Dressed

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Levi Spandauer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rosa Hutzler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Pomach

(Address) 1307 W North Ave

15- NOV 15 1921 BOARD OF HEALTH Filed ..... 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1921, to Nov 12 1921, that I saw him alive on Nov 12 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Interstial Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Anaemia

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Edgar A Kelly M. D.

Nov 14, 1921 (Address) 1134 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cem

DATE OF BURIAL, Nov 16, 1921

20-UNDERTAKER J. Aberus & Son

ADDRESS 1611 Mad Ave

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Madden.

Oper.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58582

CERTIFICATE OF DEATH.

X 170 D 58582

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine K Madden

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of John T. Madden

6 DATE OF BIRTH (month, day, and year) Oct 1st 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	0		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer): " at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Johnstown Pa

PARENTS

10 NAME OF FATHER: Christ Klemmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cameria Pa

12 MAIDEN NAME OF MOTHER: Frances Malone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Blain Pa

14 Informant: Records of Mt Hope
(Address): Mt Hope Md

15 Filed NOV 15 1921, 19 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1921, to Nov 15, 1921, that I last saw h alive on Nov 14, 1921, and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Chr. Ren. Nephritis (34½) Complicated by Nephritis (34 yrs) and acute Pul. Congestion (3 days)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Decubitus Gangrene

(duration) 3 yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? Hollidaysburg Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Tamney, M. D.

Nov 15. 1921 (Address) Mt Hope

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hollidaysburg Pa — DATE OF BURIAL: Nov 15 1921

20 UNDERTAKER: HENRY G. MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58583

64 D 58583

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

No. Mercy Hospital St. 19 Ward)

2-FULL NAME Mrs. Catherine Martin

(a) RESIDENCE. No. 347 S. Calhoun St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McMahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nancy Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Lawson

(Address) 347 S Calhoun St

15 Filed NOV 15 1921, 19 H. Helms Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1921, to Nov 13, 1921, that I last saw her alive on Nov 13, 1921, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (Hemorrhage) 2 hrs.

(duration)

CONTRIBUTORY (Secondary) Hypostatic Pneumonia 44 hrs.

Cardiac failure 23 hrs. (5)

(duration)

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Symptoms

(Signed) John J. Brown, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 16 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 W North Ave.

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. Mary O Hallwig

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58584 — CERTIFICATE OF DEATH. — D 58584

1-PLACE OF DEATH 103

CITY OF BALTIMORE: (No 108 N Fulton ave ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Phyllis Hallwig

(a) RESIDENCE. NO. 108 N Fulton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Oscar A Hallwig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Bartley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Oscar Hallwig 103 N Fulton ave

15 Filed NOV 15 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 th. 1921, to Nov 14 th 1921.

that I last saw h s alive on Nov 14 th. 1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diphtheria Laryngeal

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Membrane

(Signed) W. Lan Williams M. D.

, 19 (Address) 901 Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	11/15/21

20 UNDERTAKER: Geo A Farley Fulton & Fayette — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should take mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58585

CERTIFICATE OF DEATH.

89 D 58585

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 8 Longwood Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Katharine Reynardt

(Residence in Baltimore: No. 8 Longwood Road St.; 71 yrs., ... mos. ..... ds.)

+ +

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July (Month) 26 (Day), 1847 (Year)

7-AGE, 77 yrs. 3 mos. 19 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John H. Smith

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Adalaide Kramer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Harriet Reynardt

(Address) 8 Longwood Road

15-

Filed NOV 15 1921 19.. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov- (Month) 14 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct-20 1921, to Nov-14 1921, that I saw her alive on Nov-13 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis (diffuse)

(Duration) ... yrs. — mos. 24 ds.

CONTRIBUTORY (Secondary) Embolus in Pop- Iliac Artery (left)

(Duration) ... yrs. ... mos. 1 ds.

(Signed) M. ... Porter M. D.

11/14, 1921 (Address) 422 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, 11/15, 1921

20-UNDERTAKER Geo A Farley Fulton

ADDRESS Fayette

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58586

HEALTH DEPARTMENT—CITY OF BALTIMORE

58586

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3578 Parkdale Ave ST.; 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Wink

(Residence in Baltimore: No. 35-18 (1604 Dolphin Ave St.; 30 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., (Month) (Day) 1 (Year)

7-AGE, 76 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Asked but Known

11-BIRTHPLACE OF FATHER (State or Country) Ask but Known

12-MAIDEN NAME OF MOTHER Ask but Known

13-BIRTHPLACE OF MOTHER (State or Country) Ask but Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Wink

(Address) 3578 Parkdale Ave

15- NOV 15 1921

Filed....., 191.... J. H. Wehn Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12th 1921, to Nov 14th 1921, that I saw h[er] alive on Nov 13th 1921, and that death occurred, on the date stated above, at 3.00 A m.

The CAUSE OF DEATH* was as follows:

0737

General Carcinomatosis

..... (Duration) ..... yrs. 10 mos. ..... da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. 10 mos. ..... da.

(Signed) W. H. Fellows M. D.

11/17, 1921 (Address) 18 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Nov 14, 1921

20-UNDERTAKER P. S. Marshall

ADDRESS 3559 Fait Rd

N. B.—Every item of information should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Orginated in Left breast.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58587

CERTIFICATE OF DEATH.

✓ 64-091

D 58587

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

2-FULL NAME Yetta Bierfeld

(a) RESIDENCE NO. 1253 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj Bierfeld

6 DATE OF BIRTH (month, day and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J Lewis

(Address) 1411 E Baltimore St

15 NOV 15 1921 BOARD OF HEALTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/21 19

17 I HEREBY CERTIFY, That I attended deceased from 10/12/21 19.. to 11/14/21 19

that I last saw h e alive on 11/14/21 19

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) H Finby M. D.

11/15 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Harmony Plot — DATE OF BURIAL 11/15 19 21

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. If unknown, approximate estimate should be supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 58588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58588

CERTIFICATE OF DEATH.

REGISTERED NO. C 58

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 W Lexington ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry B Woodall.

(Residence in Baltimore: No. 1300 W Lexington St.: 15 yrs.. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not Known, 1— (Month) (Day) (Year)

7-AGE, 67 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) — 086

9-BIRTHPLACE, (State or Country), Del.

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Del

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Del

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna R Woodall

(Address) 1300 W Lexington St

15-

Filed NOV 15 1921 191... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Nov 13 1921, that I saw h-- alive on Nov 13 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(Duration) yrs. mos. ds.

(Signed) C. D. Driscoll, M. D.

Nov 14, 1921. (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Colchester Kent Co Md — DATE OF BURIAL, 11—16, 1921

20-UNDERTAKER Mrs Chas A G Rohde — ADDRESS Arlington Ave

N. B.—Every item of information should be carefully supplied. All CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Estella Perry ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58589

8-091

CERTIFICATE OF DEATH.

D 58589

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2331 N. Fapplelton ST., 18 WARD)

2-FULL NAME Estelle Perry

(a) RESIDENCE NO. 2331 N. Pappleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE BLANKS should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Ernest Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dora Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Dora Perry
(Address) 2331 N. Pappleton St

15 Filed NOV 15 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11th, 1921, to Nov. 14th 21.
that I last saw h[illegible]ive on Nov. 13th, 1921,
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Bronchis Pneumonia

(duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) ... yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Victor Ellis M. D.

11/17 1921 (Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 15 1921
20 UNDERTAKER	ADDRESS 1141 W.
Brown & Leland	Baltimore

Spec.—6-9-18—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58590 — 1-PLACE OF DEATH — D 58590 REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital St.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Gillespie

(a) RESIDENCE. No. 1926 N. Fairfield Md St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — John Gillespie

6 DATE OF BIRTH (month, day, and year) May 8 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) — Md.

PARENTS

10 NAME OF FATHER — William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Md

12 MAIDEN NAME OF MOTHER — Mary Holbrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Md.

14 Informant — John Gillespie

(Address) — Fairfield Md

NOV 15 1921 — ROBT. J. KRAFFT Registrar

Burial Permit Issued Summerset Co. Md. B C M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1921, to Nov 14, 1921, that I last saw h[illegible] alive on Nov 14, 1921, and that death occurred, on the date stated above, at 2.220 m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac failure 3 days

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Signs & Symptoms

(Signed) John E Bowen M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tyaskins Md Ct	Nov. 16 1921
20 UNDERTAKER	ADDRESS
J. W. Brown and Son	108 W. Monty Pier 1 Pratt St.

N. B.—WRITE PLAINLY, with ink. PHYSICIAN'S NAME and OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of DATE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58591 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58591

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2720 Bernard St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna May Timmons

(Residence in Baltimore: No. 2720 Bernard St.) 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Sgl

6-DATE OF BIRTH, (Month) Sept (Day) 16, (Year) 1921

7-AGE, ... yrs. 1 mos. 29 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James F Timmons

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER, Carol McGinnis

13-BIRTHPLACE OF MOTHER (State or Country) Saint Louis Mo

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James F. Timmons

Address 2720 Bernard St

15- Robert P. Harrison

Date NOV 15 1921, 191.... Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Nov (Day) 14, (Year) 1921

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Nov 14 1921 (Address) 2122 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem Co

DATE OF BURIAL, Nov 16, 1921.

20-UNDERTAKER William Cahill

ADDRESS 5026 Reisterstown Rd

By Monnes

Spec.—1-10-21—M&T—1500 Bks.

D 58592 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58592

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Reservoir Street ST., 13 WARD)

2-FULL NAME Carmel M. Magowan

(a) RESIDENCE NO. 717 Reservoir Stred ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora V. Magowan

6 DATE OF BIRTH (month, day, and year): June 23-1869

7 AGE: Years 52; Months; Days; If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): United States Service

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER: Robt Magowan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Sarah Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant: Cora V. Magowan

(Address): 717 Reservoir St

Robert F. Harrison

NOV 15 1921, 19.....

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to Nov 14th, 1921, that I last saw him alive on Nov 14th, 1921, and that death occurred, on the date stated above, at 1.34 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary Analysis

(Signed) A. C. Samuels, M. D.

(Address) 4509 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Nov 17 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS FORM MUST BE FILLED OUT EXACTLY. PHYSICIAN'S abbreviate mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D 58593

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 N. Calvert ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jirge T. Reed

(a) RESIDENCE NO. 635 N. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary A. Reed

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Matthew Eberhardt

(Address) 635 N Calvert

15 Filed ....., 19.....

Robert F. Harrison,

Burial Permit Clerk.

Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

NOV 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1921, to Nov 13, 1921, that I last saw him alive on Nov 13, 1921, and that death occurred, on the date stated above, at 5:20 p m.

The CAUSE OF DEATH* was as follows:

Fractured hip (left) (Fall)
with exhaustion

(duration) yrs. 2 mos 9 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jno T Callaghan M. D.

Nov 14 1921 (Address) 1038 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Nov 16 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58594

CERTIFICATE OF DEATH.

40

D 58594

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 952 Homestead ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua T. Knight

(a) RESIDENCE NO. 952 Homestead ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or Wife of~~ Lorena B. Knight

6 DATE OF BIRTH (month, day, and year) July 24th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	79	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles R Knight

(Address) 952 Homestead St

15 Filed NOV 15 1921 J E Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 13 1921 to Nov 14 1921

that I last saw him alive on Nov 13 1921

and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia & Pulmonary Embolism (duration) mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of

Was there an autopsy? ~

What test confirmed diagnosis? ~

(Signed) ~~J T Stout~~ M. D.

, 19 (Address) 1929 Monta

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon Harford Co. Md	Nov 17th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIANS' and undertakers' information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58595 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58595

CERTIFICATE OF DEATH.

K 24 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. off Pier 5 Locust Point. ST. WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Bage.

(Residence in Baltimore: No. on barge 102 off Locust Point. St.; yrs. — 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male.	White.	Unknown.

6-DATE OF BIRTH, Do not know. (Month) , 1 (Day) (Year)

7-AGE.	If LESS than 1 day,
40 yrs. mos. ds.	hrs. or min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Captain of
(b) General nature of industry, business, or establishment in which employed (or employer): Barge 102

9-BIRTHPLACE, (State or Country). New York.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Report.

(Address)

15- Robert P. Harrison,

Filed NOV 15 1921, 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 31, 1921
Body found November 9th, 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probable accidental fall from boat.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

Nov. 15, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Nov 15 1921
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58596 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58596

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 22 WARD) 79 REGISTERED NO. C

2-FULL NAME Augustus M. Aaron.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 43 E. Hill St.) 68 ------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, June 10th. 1850, 1 (Month) (Day) (Year)

7-AGE, 71 yrs. 5 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Dorchester Co, Md.

PARENTS.

10-NAME OF FATHER, Marcellus Aaron.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Emily Tall.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Aaron. (brother)

(Address) 103 Warren Ave.

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk, Registrar.

NOV 15 1921

WRITE PLAINLY.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) [signature] M. D. (Coroner)

Nov. 15th 21 191. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Nov. 16, 1921.
20-UNDERTAKER John H. Denny	ADDRESS 715 Leight St

Spec.—8-24-14—M. & T.—2000 Bks.

D 58597

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

D 58597

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 N Mulberry St.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unnamed Johnson

(Residence in Baltimore: No. 1630 N Mulberry St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	C	Single

6-DATE OF BIRTH, Nov (Month) 12 (Day), 1921 (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, 23 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, W H Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Angelina Bassett

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W H Johnson

(Address) 1162 N Franklin

15-

Filed ....., 191....

Robert F. Harrison, Registrar.

NOV 15 1921

Burial Permit Clerk

18670

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be given in every case, as it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 1921, to Nov 13 1921, that I saw h[illegible] alive on Nov 13 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Asthenia

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) William E Burton M. D.

Nov 13, 1921 (Address) 712 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL Health. NOV 15 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58598

54

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hardtome Av Hamilton ST. 27 WARD)

2-FULL NAME Isaac N Heard

(a) RESIDENCE. NO. Hardtome Av Hamilton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Harriet E Heard

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt Dept. Store

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER John M Heard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Mary Hentzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant James R Heard
(Address) 1438 W Baltimore St

15 Filed NOV 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1. 1921, to Nov. 13. 1921, that I last saw him alive on Nov. 12. 1921, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Dont know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? yes.

(Signed) Herbert C. Blake, M. D.

, 19 (Address) 1014 W. La Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov. 16 1921
20 UNDERTAKER Harry A Nitzke	ADDRESS 1531 W Lombard

H. B.—WRITE PLAINLY. All items carefully supplied. AGE should be carefully supplied. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 58599 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58599

CERTIFICATE OF DEATH. 9

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 S Decker ave ST., 1 WARD)

2-FULL NAME agnes Makowski

(a) RESIDENCE No. 742 S Decker av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Makowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Francis Kilkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Frank Makowski 742 S Decker ave

15 Filed ..... 19 ..... Registrar

NOV 15 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to Nov 15, 1921.

that I last saw her alive on Nov 14, 1921,

and that death occurred, on the date stated above, at 7 45 A.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? — (over)

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) C. A. Reifschneider, M. D.

11-15, 1921 (Address) 2939 Eastern ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Nov 16 1921

20 UNDERTAKER: John Schreiber — ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be stated EXACTLY. PHYSICIAN should make mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See Instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H 1

D 58600

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 N. Milton Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K. Duvall

(a) RESIDENCE. No. 823 N. Milton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs — mos. — ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T. M. Duvall

6 DATE OF BIRTH (month, day, and year) Jan. 27-1858

7 AGE Years 63 Months 9 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Maryland

PARENTS

10 NAME OF FATHER Abraham Leister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Levinah Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md.

14 Informant Charles T. M. Duvall (Address) 823 N. Milton Ave

15 Filed NOV 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Nov. 12th, 1921, that I last saw her alive on Nov. 12th, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Intestinal)

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? X Ray.

(Signed) Robert S. Kirk, M. D.

11/14, 1921 (Address) 2126 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown M. E. Cemetery

DATE OF BURIAL Nov. 16 1921

20 UNDERTAKER Horace H. Burgee

ADDRESS 3631 Falls Rd.

WRITE PLAINLY. PHYSICIAN'S mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on b

Exact statement of OCCUPA- s on back of certificates.

WRITE PLAINLY.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58601

CERTIFICATE OF DEATH.

155

D 58601

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Westport woods. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Rauba.

(Residence in Baltimore: No. Elreta Ave. Washington Park. 17 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower

6-DATE OF BIRTH, March 17th. 1886, 1 (Month) (Day) (Year)

7-AGE, 35 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Lithuania.

PARENTS.

10-NAME OF FATHER, Melvin Rauba.

11-BIRTHPLACE OF FATHER (State or Country), Lithuania.

12-MAIDEN NAME OF MOTHER Anna Polackis.

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Oakionas, (sister)

(Address) Elreta Ave, Washington Park.

15-

Filed NOV 15 1921 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 12th. 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autaau.. (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autaau (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic acid poisoning,
Suicide
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D. (Coroner.)

Nov. 15th. 21 (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem.	Wednesday 16 1921
20-UNDERTAKER	ADDRESS
M.M. Cook	Walbrook

D 58602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 300 S. Stricker St. ST.) 19 (WARD)

REGISTERED No. C 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Crose

(Residence in Baltimore: No. 300 S. Stricker St.)

Sex yrs., 67 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, June (Month) 7th (Day), 1837 (Year)

7-AGE, 84 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Builder-Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 1890

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Crose

(Address) 300 S. Stricker St.

15-

Filed NOV 16th 1921 191.... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 15th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxia by Suicide

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(Duration) yrs. mos. 1 ds.

(Signed) C B Cadle M. D. (Coroner.)

Nov 15, 1921 (Address) 1436 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Nov 17, 1921

20-UNDERTAKER	ADDRESS
Joseph B Cook	1003 N Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(See affadavit over)

D 58603 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58603

80

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1648 E. Pratt ST., 3 WARD)

2-FULL NAME Sarah Sandler

(a) RESIDENCE NO. 1648 E Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 23 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Sandler

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis 1411 E Baltimore

(Address)

15 Filed NOV 16 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 19 21, to Nov 16, 19 21,

that I last saw h.. alive on Nov 16, 19 21,

and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ? Date of .....

Was there an autopsy? ? .....

What test confirmed diagnosis? .....

(Signed) Dr. Cohen, M. D.

11/16, 19 21 (Address) 2231 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 11/16 1921

20 UNDERTAKER Jack Lewis 1411 E Balto St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Carriages and Limousines
FOR ALL OCCASSIONS
PHONE, WOLFE 864

JACK LEWIS
Funeral Director & Embalmer
1411 EAST BALTIMORE STREET

Private Ambulanc
AT SHORT NOTIC
OPEN DAY AND NIGHT

BALTIMORE, MD., Nov. 23 19

Nov 16-1921

State of Maryland
City of Balto.

To wit: Before me the subscriber a Notary Public of the State of Maryland, in and for the City of Balto. appeard Louis Landau, and made oath in due form of law that the name of his wife is Ida Landau instead of Sarah Landau which is incorrect and given at time of great distress Louis Landau

Sworn to and subscribed before me this 23rd day of November, 1921.
Moses Bogat

Spec.—8-24-14—M. & T.—2000 Bks.

Harlan Gathan

D 58604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58604

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 N. Central Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harlan Gathan

(Residence in Baltimore: No. 723 N. Central Ave St.; 80 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Femal

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, — — 1 (Month) (Day) (Year)

7-AGE, 83 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) House Work

9-BIRTHPLACE, (State or Country), Live in Baltimore 48 years N C

PARENTS.

10-NAME OF FATHER, Green Clark

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G Azuilla Banks

(Address) 723 N Central Ave

15-

Filed NOV 16 1921, 191.....

NOV 1 6 1921

MORTUARY REGISTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5th 1921, to Nov 14th 1921, that I saw h[er] alive on Nov 10th 1921, and that death occurred, on the date stated above, at 10:40 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Chronic

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza

(Duration) yrs. mos. ds.

(Signed) M. D.

Nov 15th, 1921. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery

DATE OF BURIAL, Nov. 16, 1921.

20-UNDERTAKER Wm Robert A Elliott

ADDRESS 1725 Ashland Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58605

105

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 558 Orchard ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Burton

(Residence in Baltimore: No. 558 Orchard St.; 52 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 24, 1869 (Month) (Day) (Year)

7-AGE, 52 yrs. 4 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Truck hand
(b) General nature of industry, business, or establishment in which employed (or employer) D. &O.

9-BIRTHPLACE, (State or Country), born in Baltimore Balto. Md,

PARENTS.

10-NAME OF FATHER, David Burton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliz. Webster

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Burton

(Address) 558 Orchard St.

15-

Filed NOV 16 1921, 191.....

SOCIETY & CHARITIES

Social Service Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Ac. Dilatation of Heart

(Duration) yrs. mos. 1/2 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Nov. 14, 1921 (Address) 2802 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, November 16

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1726 Ashland

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 38606

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 58606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 Dover St.: 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pinder

(a) RESIDENCE. No. 743 Dover St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Henry Pinder

6 DATE OF BIRTH (month, day, and year): Unknown, 1871

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: Private

9 BIRTHPLACE (city or town) (State or country): C. C. Co. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Rose Anderson

(Address): 743 Dover St

15 Filed NOV 16 1921 19.. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1921, to Nov 14, 1921, that I last saw h[illegible] alive on Nov. 12, 1921, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Cardiac asthma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dudley Stone M. D.

11/15 1921 (Address) 729 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Nov 16 1921

20 UNDERTAKER: Samuel Hensley

ADDRESS: Biddle

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58607

CERTIFICATE OF DEATH.

9VD 58607

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Amity ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E. Forrest

(a) RESIDENCE. No. 208 N Amity ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem'l	Col'd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Sept. 25-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): NOne

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Archie M Forrest

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Edna Hushui

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Edna Forrest 208 Amity

15 Filed NOV 16 1921 19 HEALTH DEPT. Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1921, to Nov 14, 1921, that I last saw h[illegible] alive on Nov 13, 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia 4 ds.
(duration) yrs. mos.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteria

(Signed) F. C. Leuth M. D.

Nov 16 (Address) 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Grove. DATE OF BURIAL: Nov 16 1921

20 UNDERTAKER: Sam'l L Hennedy ADDRESS 578 Riddle

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be properly classified. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be properly classified. AGE should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Smothers

HEALTH DEPARTMENT—CITY OF BALTIMORE

15-1929 D 58608

CERTIFICATE OF DEATH.

78 D 58608

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Smothers

(a) RESIDENCE. No. 1414 Fairmount Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-25-19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Isaac Smothers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lydia Burnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed NOV 16 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-9, 1921, to 11-13, 1921, that I last saw h[illegible] alive on 11-13, 1921, and that death occurred, on the date stated above, at 6:35 a.m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-Ray + Lumbar puncture.

(Signed) Horace G. Stewart, M. D.

11/13, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

MX Cremation Nov. 15 1921

20 UNDERTAKER Saml. L. Kennedy ADDRESS 578 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58609

CERTIFICATE OF DEATH.

D 58609

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1268 Riverside Ave. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Marsh

(a) RESIDENCE. NO. 1268 Riverside Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Walter W. Marsh

6 DATE OF BIRTH (month, day, and year) Jan. 18 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant (Address) Mr. James Marsh 1268 Riverside Ave

15 Filed NOV 16 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Nov 15, 1921, that I last saw her alive on Nov 15, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell M. D.

Nov 16 1921 (Address) 164 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 18 1921
20 UNDERTAKER J. Fred McCully	ADDRESS 130 E. Front

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Straub)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58610

CERTIFICATE OF DEATH.

64 D 58610

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1263 Battery Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Straub

(a) RESIDENCE. No. 1263 Battery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Staut

6 DATE OF BIRTH (month, day, and year) Oct 18 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clement Altenthan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas Staut
(Address) 1263 Battery Ave

15 Filed NOV 16 1921 Registrar

BURIAL PERMIT CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1921, to Nov 14, 1921, that I last saw h alive on Nov 14, 1921, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Melville M. D.

Nov. 19 21 (Address) 1299 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co	11-18 1921
20 UNDERTAKER	ADDRESS
E & B Hartle	115 E West St

N. B.—WRITE PLAINLY, WITH CARBON. PHYSICIAN'S and UNDERTAKER'S REPORTS should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

58611

HEALTH DEPARTMENT—CITY OF BALTIMORE

58611

CERTIFICATE OF DEATH.

142

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Feete

(a) RESIDENCE. NO. 2027 Hergest St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co., Maryland

PARENTS

10 NAME OF FATHER Harrison Feete

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middletown, Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middletown, Maryland

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed NOV 16 1921 19 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14 19 21 to November 15 19 21 that I last saw h im alive on November 15 19 21 and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Gangrene of right leg.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? P

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/15/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md.	11-16 1921
20 UNDERTAKER	ADDRESS
E & B Hartle	115 E West St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58612 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58612

CERTIFICATE OF DEATH.

REGISTERED NO. 1120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2913 Penna. Ave ST. 13 WARD)

2-FULL NAME Mary Sue Wright.

(a) RESIDENCE No. 2913 Penna. Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ or) WIFE of James P. Wright

6 DATE OF BIRTH (month, day, and year) Feb. 22-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 100

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Harford County, Md.

PARENTS

10 NAME OF FATHER Wm. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County Md.

12 MAIDEN NAME OF MOTHER Esther King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County

14 Informant Edwin O. Wright.

(Address) 2913 Penna. Ave.

15 Filed ... 19... SOCIETY [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from November 9th, 1921, to November 16th 1921, that I last saw her alive on November 16th, 1921 and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis, Arteriosclerosis, Bronchitis. Final stage general weakness

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ~ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No Clinical history and examination.

What test confirmed diagnosis?

(Signed) Wilson Smith M. D.

, 19 (Address) 5005 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL - Druid Ridge Cem. DATE OF BURIAL Nov 17 1921

20 UNDERTAKER Wm J Tickner & Sons ADDRESS North St

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be careful EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 58613 D 58613 D 58613 D 58613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1019 Low street ST. 5 WARD)

2-FULL NAME Rosa Zapolith

(a) RESIDENCE NO. 1019 Low St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. Zapolith

6 DATE OF BIRTH (month, day and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Balt St
(Address) 1411

15 Filed NOV 16 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16 1921 to Nov 1921

that I last saw h W alive on October 1921

and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder
metastasis to Liver

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/19/21

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) Alfred Zellman M. D.

Nov 16 1921 (Address) 1712 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrer Rosedale	11/16 1921
20 UNDERTAKER	ADDRESS
Jack Levis	1411 E Balt

WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 58614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9/D 58614

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 S 12 d Highland Town ST.....WARD) 76

2-FULL NAME Evelyn Marie Smith

(a) RESIDENCE NO. 522 S 12th St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7/1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	6	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas P Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Estella M Berg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas P Smith (Address) 522 S 12 St

15 Filed NOV 16 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to Nov 15, 1921, that I last saw her alive on Nov 15th, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam Fod., M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Nov 18 1921
20 UNDERTAKER	ADDRESS
William Oak	5026 Belair

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58615

CERTIFICATE OF DEATH.

15 | D 58615

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Gorsuch St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Daniel Cochran

(Residence in Baltimore: No. 908 Gorsuch St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Oct (Month) 24 (Day), 1921 (Year)

7-AGE, ...yrs.....mos.22ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm J Cochran

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary G. Reilly.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Cochran

(Address) 908 Gorsuch ave

15-

NOV 16 1921

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/8/21 1921, to 11/15 1921, that I saw h[illegible] alive on 11/13 1921, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Premature birth (6-7 mos)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Hamilton for Coca of Food. Liver & pneum

(Duration).....yrs.....mos.....ds.

(Signed) Dr Bernard Wise M. D.

11/15, 1921 (Address) 914 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loug Green — DATE OF BURIAL, Nov 17, 1921

20-UNDERTAKER Wm Cook — ADDRESS 1526 E North

will drive

N.B.—Every item of information should be carefully supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58616 ✓

D 58616

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josefa Walter

(Residence in Baltimore: No. 408 S. Ann St.; 41 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female.	White.	Married

6-DATE OF BIRTH. March 19, 1845. (Month) (Day) (Year)

7-AGE. 76 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, — Zelienski.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Unknown —

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Walter.

(Address) 408 S. Ann St.

15-

Filed NOV 16 1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 15 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 1921, to Nov 15 1921, that I saw her alive on Nov. 15 1921, and that death occurred, on the date stated above, at 9:25 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) John H. Ruhberger M. D.

Nov. 15, 1921 (Address) 1709 Aliceanna

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem.; DATE OF BURIAL, Nov. 18..., 1921.

20-UNDERTAKER M. F. Sadowski. ADDRESS 905 S. Ann St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58617

CERTIFICATE OF DEATH.

D 58617

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 S. Kenwood Ave. WARD)

2-FULL NAME Mrs. Katherine Panczak

(a) RESIDENCE NO. 527 S. Kenwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Bartholomew Panczak

6 DATE OF BIRTH (month, day, and year) Jan 13 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Matthew Zarnowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dora Lukiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Adda Dobinski

(Address) 527 S. Kenwood Ave

15 Filed NOV 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Nov 13 1921, that I last saw her alive on Nov 13 1921, and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute edema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

11/14 1921 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem., DATE OF BURIAL Nov-17 1921.

20 UNDERTAKER M F. Sadowski. ADDRESS 705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58618

D 58618

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Daniel Gallagher

(a) RESIDENCE. No. 507 N. Carey St ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pipe fitter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott city md

PARENTS

10 NAME OF FATHER James D. gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co md

12 MAIDEN NAME OF MOTHER Caroline Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co md

14 Informant Wm. Starr Gallagher
(Address) 507 N. Carey Street

15 Filed NOV 16 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/11, 1921, to 11/15, 1921, that I last saw him alive on 11/14/21, 19..., and that death occurred, on the date stated above, at 1.05 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage 10 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ans Home

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Examination

(Signed) Edward Stone, M. D.

11/15, 1921 (Address) 1450 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 11-17- 1921

20 UNDERTAKER: H B Cummings Son — ADDRESS: 517 N. Schroeder st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 58619 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2407 Allendale Rd ST.: 15 WARD) REGISTERED NO. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Robertson

(Residence in Baltimore: No. 2407 Allendale Rd. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Sept. 30, 1853 (Month) (Day) (Year)

7-AGE, 68 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), England

PARENTS

10-NAME OF FATHER, ? England

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. O. Coleman

(Address) 2407 Allendale Rd

15- Filed NOV 16 1921 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

(Duration) .... yrs. .... mos. 1 .... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 7 yrs. .... mos. .... ds.

(Signed) J. T. Kemp M. D. (Coroner.)

Nov. 15, 1921 (Address) 1802 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, Nov. 17, 1921

20-UNDERTAKER H. E. Hughes

ADDRESS 4247 N. Bway

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state carefully all information asked for. AGE should be supplied. OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58620

D 58620

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4851 Park Heights Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Wekenman

(a) RESIDENCE. No. 4851 Park Heights Ave ST., WARD.

(Usual place of abode) 50

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Wekenman

6 DATE OF BIRTH (month, day, and year): Oct 2nd, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

088

9 BIRTHPLACE (city or town) (State or country): Wurtemberg Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: L. Gerhardt

(Address) 3232 Carlisle Ave

15 NOV 16 1921 [illegible] Registrar

Serial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 5 1921 to Nov 14th 1921

that I last saw h 4 alive on Nov 14th 1921

and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Bubeck M. D.

Nov 15, 1921 (Address) 4854 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 17th, 1921

20 UNDERTAKER: Bernard Gore ADDRESS 4237 Labor Ave

I. B. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58621

CERTIFICATE OF DEATH.

64 D 58621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3428 E Baltimore St.; 26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Bowen

(Residence in Baltimore: No. 3428 E Baltimore St.; 47 yrs., 10 mos. 21 ds.)

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. (Month) 24 (Day), 1873 (Year)

7-AGE, 47 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Road Supt
(b) General nature of industry, business, or establishment in which employed (or employer): U E R R Co

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Steven Bowen

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rosella Bowen

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Dora Bowen

(Address) 3428 E Balto St

15- NOV 16 1921 Filed....., 191.....

ROBERT J KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2 years about 191..., to Nov. 14 1921, that I saw him alive on Nov 13 1921, and that death occurred, on the date stated above, at about 6 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic

four years (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs....mos....ds.

(Signed) W J Riley M. D.

Nov 15, 1921 (Address) 1642 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Oak Lawn	Nov 17, 1921

20-UNDERTAKER	ADDRESS
Peter Nicolaus	Lonc Eastern

Remarks

Probably terminal cerebral hemorrhage. No lues. Wasserman negative

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc.. *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58622

CERTIFICATE OF DEATH.

28 D 58622

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 658 W Mulberry St - St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Davis

(Residence in Baltimore: No. 658 W Mulberry St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: ..... Dont Know ....., 1..... (Month) (Day) (Year)

7-AGE: 45 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (State or Country): Dont Know

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or Country): Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dan Easter

(Address) 916 Eden

15- Filed NOV 16 1921 ERNEST J. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner)

11-16 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: D J Carlin Sons — DATE OF BURIAL: Nov 18, 1921

20-UNDERTAKER: Dan Easter — ADDRESS 916 Eden

Spec.—1-10-21—M&T—1500 Bks.

D 58623

HEALTH DEPARTMENT—CITY OF BALTIMORE

150

D 58623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 S. Curley ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. L. Leonard Barb

(a) RESIDENCE NO. 20 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29 21.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER William Barb

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Celia Fabrizzal

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Wm. Barb
(Address) 20 S. Curley St

15 Filed NOV 16 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1921, to to Nov 13 1921,

that I last saw him alive on Nov 13th, 1921,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Foramen Ovale failed to close

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod, M. D.

, 19 (Address) 4704 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 11 16 1921

20 UNDERTAKER J. G. Moran

ADDRESS 3000 E. Baltoh.

N. B.—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. mation should be carefully classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58624

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 W Biddle ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Wilhelmer

(a) RESIDENCE. No. 610 W Biddle ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14-1921

7 AGE	Years	Months	Days	If LESS than 1 day 14 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alex Wilhelmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Beatrice Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washde

14 Informant
(Address) Robert P. Harrison,

Filed ..... 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 . 1921 . to Nov 15 . 1921.

that I last saw him alive on Nov 14 . 1921.

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (6 months) 14 hours
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R Caussy, M. D.

19 (Address) 753 Orange St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSPITAL — 19

20 UNDERTAKER — ADDRESS

NOV 1 1921

Commissioner Health

Attention should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Relowsky

D 58625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58625

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 522 Hanover ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert P. Relowsky

(a) RESIDENCE. No. 522 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Relowsky

6 DATE OF BIRTH (month, day, and year) July 4 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 1914

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Relowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clara Relowsky
(Address) 522 S. Hanover St.

15 NOV 16 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1921, to Nov 14, 1921, that I last saw him alive on Nov 14, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Asthma

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood

(Signed) R. P. Campbell M. D.

Nov 16, 1921 (Address) 1647 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 17th 1921
20 UNDERTAKER	ADDRESS, 834
E. Schlomanson	Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. Information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V 16 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Mitral regurgitation.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58626 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58626

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 S. Clinton St.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F Fleckenstein

(a) RESIDENCE. NO. 331 S. Clinton ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth E. Fleckenstein

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Fleckenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dorothea Krow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Agatha E Fleckenstein (Address) Ridgely Md

15 Filed NOV 16 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 13 1921

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to Nov 13, 1921, that I last saw him alive on Nov 13, 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A B Tillow M.D., M. D.

19 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	11/17, 1921
20 UNDERTAKER	ADDRESS
Wm. J. Flanagan	1116 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occu TION is very important. See instructions on back of certificates.

(Cost J. Carmack)

D 58627

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 58627

CERTIFICATE OF DEATH

120

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 4004 Belvieu Ct. St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cost J. Carmack

(Residence in Baltimore: No. 4004 Belvieu St.; 78 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Jan (Month) 8 (Day), 1838 (Year)

7-AGE: 83 yrs. 10 mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer): None 000

9-BIRTHPLACE (State or country): Fred. Co. Md.

PARENTS

10-NAME OF FATHER: Christian Carmack

11-BIRTHPLACE OF FATHER (State or country): Fred. Co. Md

12-MAIDEN NAME OF MOTHER: Mary M. Keefer

13-BIRTHPLACE OF MOTHER (State or country): Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Elizabeth J. Carmack

(Address) 4004 Belvieu St.

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk. REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If uncertain, state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 61921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept, 1920, to, Nov. 14 1921, that I saw h.... alive on Nov. 14 1921, and that death occurred, on the date stated above, at 10.30A m.

The CAUSE OF DEATH* was as follows:

Interstetial Nephritis

(Duration) 2 yrs ..... mos ..... ds.

Contributory (SECONDARY) Mitral Regurgitation

(Duration) ..... yrs ..... mos ..... ds.

(Signed), Henry Russell M. D.

11/15 ....., 191.... [Address] 3402 Frankland Av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Thurmont Frederick Md — DATE OF BURIAL: Nov-18, 1921

20-UNDERTAKER: Chas. S. Black — ADDRESS: 742 W. Pratt

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58628

CERTIFICATE OF DEATH.

170 D 58628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Mott St. 5 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Jones

(a) RESIDENCE. No. 402 Mott St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 45 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 870

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sadie Smith (Address) 402 Mott St

15 Filed NOV 17 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1921, to Nov 14th, 1921, that I last saw him alive on Nov 14th, 1921, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Picture

(Signed) David J Bell M. D

, 19 (Address) 1576 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — DATE OF BURIAL: Nov 17 1921

20 UNDERTAKER: R C Gross — ADDRESS: 1405 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58629

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. Green & Lombard ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Loesser (Loesser)

(a) RESIDENCE. NO. 122 S Calverton Rd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 16, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Erica Loesser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Volpert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records.
(Address)

15 Filed Robert P. Harrison, Registrar

V 1 61921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1921, to Nov. 16, 1921, that I last saw her alive on Nov. 15, 1921, and that death occurred, on the date stated above, at 1 AM m.

The CAUSE OF DEATH* was as follows:

Prematurity — 7½ mo Term.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo. E. Hall, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 17 — 21
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

Information should be carefully supplied. AGE should be given in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58630 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58630

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Harlem ave ST. 16 WARD)

2-FULL NAME Alice A. Farnen

(a) RESIDENCE NO. 1102 Harlem ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles T. Farnen

6 DATE OF BIRTH (month, day, and year): Dec 17-1847

7 AGE: Years 73 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: James E. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Evaline Grest

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Mrs. Collins

(Address): 1129 Lombard st

15 Filed . 19 Robert F. Harrison, Burial Permit Clerk. Registrar

V 161921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 14 19 21

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 . 1921 . to Dec 14 . 1921 .

that I last saw her alive on Dec 14 . 1921 .

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows: r

Chronic Interstitial Nephritis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary): Uraemic Coma

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. E. McClure, M. D.

(Address) 6 N. Brady

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pen Lathedral Cem.

DATE OF BURIAL: 11-17-21

20 UNDERTAKER: J. J. Moran

ADDRESS 3 and E. Balto.

IMPORTANT—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Hamilton — REGISTERED NO. 79

CITY OF BALTIMORE: (No. 2 E. Hamilton Ave ST.) 27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Tames

(a) RESIDENCE. No. 2 E. Hamilton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1st 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer) General Merchandise

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md Md.

PARENTS

10 NAME OF FATHER John H. Tames

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Catherine Geller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Charles Tames (Address) 2 E. Hamilton Ave. Hamilton

15 Filed Nov 16 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to Nov 15, 1921, that I last saw h[illegible] alive on Nov 15, 1921, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Indigestion & Dyspepsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

11/16, 1921 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov. 17 1921
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fulton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Any OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58632

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 w. North Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie Bennett Rollins

(a) RESIDENCE. No. 1931 w. North Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	white	widow

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Louis N. Rollins

6 DATE OF BIRTH (month, day, and year) May 18. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 400

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co Md

PARENTS

10 NAME OF FATHER John W. Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Locker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Rosa Smith
(Address) 1931 w. North ave

15 Filed Nov 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1921. to Nov. 16, 1921.

that I last saw her alive on Nov. 16, 1921.

and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

arterio Sclerosis
Chronic Interstitial
Nephritis 2

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) K. C. Mettle, M. D.

Nov 16 1921 (Address) 1903 E. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys City St Mary Co Md	Nov. 19 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1948 W. North Ave

V 16 1921

mation should be carefully supplied. AGE and
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D 58633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58633

CERTIFICATE OF DEATH.

64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Harlem ST., 16 WARD)

2-FULL NAME Louisa C. Thiem

(a) RESIDENCE NO. 905 Harlem ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(w) WIFE of John Thiem

6 DATE OF BIRTH (month, day, and year) Aug 3/43

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	3	12	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John H. Kabernagle

11 BIRTHPLACE OF FATHER (city or town) Hanover
(State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa C. Hellman

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant John J Thiem
(Address) 905 Harlem Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

NOV 16 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1924, to Nov 15, 1924,
that I last saw h alive on Nov 14, 1924
and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Left side Paralyzed
(Cerebral hemorrhage)
(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Insanitation, Senility (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. Kuff, M. D.

Nov 15, 1924 (Address) 1062 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park DATE OF BURIAL Nov 17 1924

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson Ave

N. B.—WHITE PERMITS ONLY to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling this blank. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling this blank. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation may be required by Clerk of certificates. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58634

D 58634

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson Brooks

(a) RESIDENCE. No. 811 E Mulberry st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred (19 years) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 049

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joe Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Nellie Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records
(Address) M.T.H.

15 Filed 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

NOV 16 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1921, to Nov. 15, 1921, that I last saw h im alive on Nov. 15, 1921, and that death occurred, on the date stated above, at 11.35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? B. in sputum, X-ray

(Signed) Francis L. Dalaglacca, M. D.

11-15-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery

DATE OF BURIAL: Nov 17th 1921

20 UNDERTAKER: Felix B. Pyc

ADDRESS: 102 E Mulberry St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 58635

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 58635

CERTIFICATE OF DEATH

92 V

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Maple Ave. near Forrest Park Ave. ST.: Franklintown (New annex) WARD) 28

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Henry Bonsall

(Residence in Baltimore: No. Maple Ave. near Forrest Park Ave. St.: Franklintown New annex yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6 DATE OF BIRTH: February 23rd (Month) (Day), 1851 (Year)

7 AGE: 69 yrs. 8 mos. 23 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Plasterer (Self)
(b) General nature of industry, business, or establishment in which employed (or employer): 157

9 BIRTHPLACE (State or country): Towson, Md.

PARENTS

10 NAME OF FATHER: John M. Bonsall

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: ? Bowen

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Bonsall

(Address) Franklintown Md.

15 Robert P. Harrison, (Date) NOV 16 1921 (By) Burial Permit Clerk REGISTRAR

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: NOV (Month) 15 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from NOV 11, 1921, to NOV 15 1921, that I saw h[illegible] alive on NOV 14, 1921, and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 4 ds

Contributory (SECONDARY) Lobar pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) W. D. Hobbett M. D.

....., 191 . (Address) 2220 Harrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lorraine Cem — DATE OF BURIAL: Nov 18 1921

20 UNDERTAKER: Joseph B Cook, — ADDRESS: 1003 W Balto St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58636

CERTIFICATE OF DEATH.

19

D 58636

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 402 Brown Ct ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Johnson

(Residence in Baltimore: No. 402 Brown Ct. 48 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, — (Month) — (Day) 1 (Year)

7-AGE, 64 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Jan'
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country) born in Va' live in Baltimore 45 Years

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lenora E Johnson

(Address) Washington D C

15- Filed NOV 17 1921 191... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valv Dis.
Heart.
Dont Know (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) W J Riley (Coroner) M. D.

Nov 16, 1921 (Address) 1039 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, November 17 1921

20-UNDERTAKER Jno Robert A Elliott — ADDRESS 1725 Ashland Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Blks.

D 58637

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-09 D 58637.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 Gilmor ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Smith

(a) RESIDENCE No. 324 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	3	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Melvin Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Gertrude Tommy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Melvin Smith

(Address) 324 N Gilmor St

15 Filed NOV 17 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 8 1921 to Nov 16 1921.

that I last saw h.. alive on Nov. 16 1921.

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Finy M. D.

11/17 1921 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Nov 17 1921

20 UNDERTAKER Samuel T Hurley ADDRESS 5 N W Baltimore St

AGE should be stated in years, months and days if under one year. Exact statement of OCCUPATION should be carefully supplied. Avoid use of general terms, such as laborer, clerk, etc. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58638

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58638

CERTIFICATE OF DEATH.

92-079

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

John Matulevichius

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Dover ST. 27 WARD)

2-FULL NAME John Matulevichius

(a) RESIDENCE. No. 118 Dover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saloonkeeper
(b) General nature of industry, business, or establishment in which employed (or employer) 04
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Adom Matulevicus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mage Jurgicute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lith.

14 Informant Mary Matulevicus
(Address) 118 Dover St

15 NOV 17 1921 REGISTERED
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12 1921 to Nov. 15 1921
that I last saw him alive on Nov. 15 1921
and that death occurred, on the date stated above, at 4:20 P. m.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) F. B. Bromphas M. D.
11-15 1921 (Address) 615 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 18 1921
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 Paca St.

mation should be carefully supplied. Any attempt to CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

ay be properly classified. Exact statement of OCCUPA-
ck of certificates.

Spec.–1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58639

CERTIFICATE OF DEATH.

91 D 58639

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Brunt ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eldridge H. Trott

(a) RESIDENCE NO. 1816 Brunt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Feb. 14 1920

7 AGE: Years 1; Months 8; Days; If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): girl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Eldridge Trott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Viola Garrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Eldridge Trott 1816 Brunt

15 Filed NOV 17 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1921, to Nov 15, 1921, that I last saw h~~im~~ alive on Nov 15 1921, and that death occurred, on the date stated above, at 10 P/M m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1/2 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical history

(Signed) Paul Brown, M. D.

11 16 1921 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Nov 18 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 North Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

As far as Dr. Brown knew nothing else but bronchopneumonia.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58640

CERTIFICATE OF DEATH.

78 D 58640

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Dund Apts Royal & Reservoir ST. 13 WARD)

2-FULL NAME Harry S Robinson Jr.

(a) RESIDENCE NO. Dund Apts Royal & Reservoir ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Harry S Robinson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Freeman

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Harry S Robinson Jr.
(Address) Dund Apts

15 Filed NOV 17 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1921, to Nov 15, 1921, that I last saw h[illegible] alive on Nov 15, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) E B Stubbert M. D.

, 19 (Address) 1007 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dund Ridge — DATE OF BURIAL Nov 17 1921

20 UNDERTAKER J D Mitchell — ADDRESS 1231 W Fayette St

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE, PLACE OF DEATH and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of septicaemia unknown. Suddenly taken twenty two days before death. Prior to this had no heart trouble whatever

D 58641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D 58641

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. U. Hg. Hospital, St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Paulus

(Residence in Baltimore: No. 535 S. Monroe St.

Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 31, 1902
(Month) (Day) (Year)

7-AGE, 19 yrs. 10 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Boilermaker's Helper
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, John Paulus

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Tressia Karl

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Paulus

(Address) 535 S. Monroe St

15- Filed NOV 17 1921, 191 ... Register.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to *Her death on the day stated above.

*The CAUSE OF DEATH was as follows:

Motor Cycle Accident

Multiple Fractures

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

(Signed) G. Le. Blades M. D.
(Coroner.)

Nov. 17, 1921 (Address) 1432 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 11/18/21, 19...

20-UNDERTAKER Knull & Son

ADDRESS 1227 N. Paca St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58642

D 58642

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 514 Bloom (St.:) 14 (Ward)

2-FULL NAME Jane Taylor

(a) RESIDENCE: No. 514 Bloom St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of James Taylor.

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wash & Iron

(b) General natore of Indostry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Rose

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Osborne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Osborne (Address) 514 Bloom St.

15 Filed NOV 17 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1921, to Nov. 14, 1921, that I last saw h.. alive on Nov. 14, 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam

(Signed) William Humphrey M. D.

Nov 15, 1921 (Address) 1209 Presbury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Nov 17 1921
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1400 Mosher

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58643

CERTIFICATE OF DEATH.

91-081 D 58643

D 58643

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brown

(a) RESIDENCE. No. 120 Dover St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed NOV 17 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from September 22 1921 to November 10 1921.

that I last saw him alive on November 10, 1921.

and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

11/11/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Nov 17 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

mation should be carefully supplied. Any information that may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58644

430 58644

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3643 Eutaw St.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Stoel

(a) RESIDENCE. NO. 3643 Eutaw St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 24 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Aganum

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Adolph Stoel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Keelsdorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Stoel (Address) 4922 Reisterstown Rd

15 Filed NOV 17 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Mar 15, 1927, that I last saw her alive on Mar 14, 1927, and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of about Dec 1. 26

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Microscopic

(Signed) H. W. Jones, M. D.

, 19 (Address) Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 18 1927

20 UNDERTAKER C. W. Dill — ADDRESS 310 Fallsway

information should be carefully supplied. Any unknown facts may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58645

CERTIFICATE OF DEATH.

119

D 58645

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3542 Roland Ave ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Stiffler

(a) RESIDENCE. NO. 3542 Roland Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Stiffler

6 DATE OF BIRTH (month, day, and year) Oct 24 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Stiffler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cathern Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Phillip Stiffler (Address) 3545 Rolandale

15 Filed NOV 17 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1921, to Nov 15, 1921, that I last saw h[illegible] alive on Nov. 15, 1921, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Agt Bronchitis
Disease

(durstion) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Thorner M. D.

Nov 17, 1921 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 18 1921
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut Ave

mation should be carefully supplied. Age should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr Heller

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58646

CERTIFICATE OF DEATH.

64

D 58646

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 240 S. Wolfe ST.: W (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Rettner

(a) RESIDENCE. No. 240 S. Wolfe ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Rettner

6 DATE OF BIRTH (month, day, and year) April 3rd 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Rettner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Rettner
(Address) 240 S. Wolfe St

15 [illegible] 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12 – , 1921 , to Nov 15 , 1921 , that I last saw him alive on Nov 15 , 1921 , and that death occurred, on the date stated above, at 7 45 p m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) Geo Heller M. D.

(Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov. 19th 1921

20 UNDERTAKER Lilly & Zeiler

ADDRESS 400 S. Wolfe

mation should be carefully supplied. Any suspicious circumstances relating to the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

No Pellagra ✓

D 58647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58647

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 631 S. Linwood St.; 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gannon

(a) RESIDENCE No. 631 S. Linwood St., 1 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Married~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Gannon

6 DATE OF BIRTH (month, day, and year) March 2nd 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Barney Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catharine Tierney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Gannon
(Address) 631 S. Linwood ave

15 Filed NOV 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1921. to Nov. 16, 1921.

that I last saw her alive on Nov. 16, 1921.

and that death occurred, on the date stated above, at 11 25 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine

(Signed) Eugene L. Perrazzo M. D.

Nov. 17, 1921. (Address) Ten Hills - Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov 21 19
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Marcella F. Hahs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58648

CERTIFICATE OF DEATH.

D 58648 REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Marcella F. Hahs

(Residence in Baltimore: No. 1027 S Bouldin St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	Single

6-DATE OF BIRTH, Feb. (Month) 26th (Day) 1920 (Year)

7-AGE, 1 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm Horbel.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Anna B. Albright

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna B. Horbel (Mother)

(Address) 1027 S. Bouldin St

15- Filed NOV 17 1921, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 14 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, pulled hood of soup over on self.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Kemp Bradley M. D.
(Coroner.)

11-16 1921 (Address) 4 Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Sacred Heart Cem.	Nov. 17th, 1921

20-UNDERTAKER	ADDRESS
Lilly & Zeiler	1038 Wash. Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58649

CERTIFICATE OF DEATH.

40 D 58649

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S. Regester ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthias G. Backert

(a) RESIDENCE. NO. 217 S. Regester ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Mary Backert

6 DATE OF BIRTH (month, day, and year) Mch 21st 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	23	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Door Man at

(b) General nature of industry, business, or establishment in which employed (or employer) Chester Moving

(c) Name of employer Picture Show

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Andrew Backert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Lippert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Valentine Backert Son 217 S Regester St.

15 Filed NOV 17 1921 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1921, to Nov 14, 1921, that I last saw h alive on ....., 19..., and that death occurred, on the date stated above, at 12 35 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Jos H Rudolph M. D.

11-14, 1921 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Holy Redeemer Cemetery	
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4033 Wolfe St

I. B.—WRITE plainly with pen and ink. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Goetz

D 58650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 58650
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Eastern ave & Ellwood ave St.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jasper G. Goetz

(Residence in Baltimore: No. 3730 Claremont St. St.; yrs., 66 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Aug 6, 1855
(Month) (Day) (Year)

7-AGE, 66 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Goetz

(Address) 29 E Monument St

15-

Filed NOV 1 1921, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Wesley Law (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Wesley Law find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas Law M. D.
(Coroner.)
Nov 16 1921 (Address) 1500 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	11/18/21
20-UNDERTAKER	ADDRESS
Lilly & Sons	403 W Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58651

D 58651

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Esplanade apt ST.: 13 WARD)

2-FULL NAME Bertha Hamburger

(a) RESIDENCE. No. Esplanade apt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Hamburger

6 DATE OF BIRTH (month, day, and year) November 3, 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	-	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Samuel Hamburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Kohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Manes Hamburger.
(Address) Hanover & Baltimore Sts

15 Filed NOV 17 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 16 1921

17 I HEREBY CERTIFY, That I attended deceased from November 11 19 21, to November 16, 19 21, that I last saw her alive on November 16, 19 21, and that death occurred, on the date stated above, at 6 25 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. T. Hartman, M. D.

, 19 (Address) 141 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Nov. 18 1921
20 UNDERTAKER	ADDRESS
David Sondheim	1018 W. Lexington

mation should be carefully supplied. AGE should be stated in the last birthday. If the deceased was a child or infant, the AGE at last birthday in the case of those who have lived less than one day should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

55 D 58652

REGISTERED NO.

D 58652

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Hudson Ave ST.) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie L. Rice

(a) RESIDENCE. NO. 3012 Hudson Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Most of Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. W. F. B. Rice

6 DATE OF BIRTH (month, day, and year) Oct 27 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jno K. Deudenbricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary H. Bragg.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant: Helen Rice (Address) 3012 Hudson Ave.

15 Filed NOV 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1921, to Nov. 15, 1921, that I last saw h er alive on Nov. 15, 1921, and that death occurred, on the date stated above, at 10 22 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Insipidus.

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Shannon M. D.

11/16 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Nov 18 1921

20 UNDERTAKER ADDRESS

John B. Spence, 1325 N. Carolina Ave

mation should be carefully supplied. Age should be stated in years. Exact statement of OCCUPA-
may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58653 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58653

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No Nursery & Child's Hosp 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Connor

(a) RESIDENCE. No. N. & C. Hosp. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER De Leon Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Margaret Gerhold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant De Leon Connor
(Address) 111 Garrison Lane

15 NOV 17 1921 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1921, to Nov. 15th, 1921, that I last saw her alive on Nov. 15, 1921, and that death occurred, on the date stated above, at 12:25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Intoxication

(duration) ..... yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Acidosis

..... (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Mae P. Finnegin, M. D.

19 (Address) 2008 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov. 17 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schwab	1015 Eutaw Pl

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58654

CERTIFICATE OF DEATH.

79 D 58654

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1115 Winchester ST., 16 WARD)

2-FULL NAME William Ruso

(a) RESIDENCE NO. 1115 Winchester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henretta Ruso

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	60	?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co (State or country) Va.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Sadie Ruso (Address) 1115 Winchester St

15 Filed NOV 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to Nov 14, 1921, that I last saw h[illegible] alive on Nov 16, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) C William Fiery M. D.

11/17, 1921 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 19 1921
20 UNDERTAKER	ADDRESS
Edward Ruzgold	1463 Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58655

D 58655

13530

CERTIFICATE OF DEATH.

REGISTERED NO. 14

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, St.: 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosemary Knauff

(a) RESIDENCE. No. 424 Fayette Street St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Years 5 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 21st 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Knauff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Katie Garrity

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed Nov. 19, 1921 Albert F. Harrison Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th, 1921, to Nov. 17th, 1921, that I last saw h[illegible] alive on Nov. 17th, 1921, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Stool culture Herrmann

(Signed) Horace G. Stewart, M. D.

11/17, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem.

DATE OF BURIAL 11/18, 1921

20 UNDERTAKER Chas. F. Evans & Son ADDRESS 1810 W. Mt. Royal Ave.

11/17/1921

Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58656

CERTIFICATE OF DEATH.

18

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Russell

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wright Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

NOV 17 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from November 11 1921 to November 16 1921.

that I last saw her alive on November 15, 1921.

and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

11/16/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 17 1921
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad ave

mation should be carefully supplied. Any omission CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

...may be properly classified. Exact statement of OCCUPA-
...back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58657 ✓ D 58657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) 27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Alfred J. Goodrich

(a) RESIDENCE. No. 10 Meade Rd. Roland Pk. (St.) (Ward.) Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20? yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. 3 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Alice Goodrich

6 DATE OF BIRTH (month, day, and year) Aug. 7 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ins. Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Ins. 086

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Marcellous Goodrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Rosanne Fabman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Mrs Alex R Goodrich (wife)

(Address) 10 Meade Road

15 Filed NOV 17 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4 1921, to Nov. 16 1921, that I last saw him alive on Nov. 16 1921, and that death occurred, on the date stated above, at 1:20 a m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous appendicitis 24 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis & Toxemia

Septicemia (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Nov 4 1921

Was there an autopsy? no

What test confirmed diagnosis? Findings at Operation

(Signed) John H Bowen, M. D.

19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Nov 18 1921

20 UNDERTAKER J. F. MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Burial Permit Clerk

mation should be carefully supplied. All items should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1600 Bks.

D 58658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58658

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Bell Ave ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Fiedler

(a) RESIDENCE. NO. 501 Bell Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 27, 1921

7 AGE — Years: — Months: 8 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Nicholas Fiedler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria-Hungary

12 MAIDEN NAME OF MOTHER Agnes Hildebrandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria-Hungary

14 Informant Mr Nicholas Fiedler
(Address) 501 Bell AVE.

15 Filed NOV 17 1921 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17. 1921

17 I HEREBY CERTIFY, That I attended deceased from October 12, 1921, to Nov. 17. 1921, that I last saw her alive on Nov. 16 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Empyaema

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Marr M. D.

Nov. 17. 1921 (Address) 801 E. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. Co.	11/18/ 1921
20 UNDERTAKER	ADDRESS
John J. Fahey & Son	1318 Light

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

After Child was 4 or 5 days old began
to vomit. Diet changed but after
5 or 6 weeks gastro intestinal
disturbance again appeared off &
on. Child was very weak & had
had fallen away very much.
Took cold, developed pleurisy,
& finally developed empyema.
No congenital trouble. Not tuberculous. Full term baby.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58659

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58659

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris L. Lewis

(a) RESIDENCE. No. 1124 Low St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ? 11-26/21/9

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hospital Records
(Address) Municipal Hospital

15 Filed Burial Permit Clerk Registrar

NOV 17 1921

Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from October 7, 1921, to November 15, 1921, that I last saw h.[illegible] alive on November 15, 1921, and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

(Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Burial Cemetery	Nov 18 1921
20 UNDERTAKER E Bryan	ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. If any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58660

CERTIFICATE OF DEATH.

92 D 58660

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 N. Charles St. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret B. Murphy.

(a) RESIDENCE. NO. 318 N. Charles St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. Lee Murphy.

6 DATE OF BIRTH (month, day, and year) Jan. [illegible] 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John . Cathcart

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Winters

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant J. Lee Murphy.
(Address) 318 N. Charles St.,

15 Filed Robert P. Harrison, Registrar

NOV 17 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8th, 1921, to Nov. 15th, 1921, that I last saw her alive on Nov. 15th, 1921, and that death occurred, on the date stated above, at 8 a.m. P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia. (Influenzal?)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum & course of disease

(Signed) John Blatford, M. D.

Nov 17th, 1921 (Address) 40 W. Biddle st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov. 18 1921
20 UNDERTAKER	ADDRESS
George A. Farley Fulton &	Fayette.

...mation should be carefully supplied. AGE should be stated EXACTLY. ...CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 58661

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Gettier

(a) RESIDENCE. No. Home for the Aged of the M E Church ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. ✓ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Robt Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Dennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Ella Cuddy (Address) Home for the Aged

15 NOV 17 1921 19 Robert P. Harrison, Registrar
Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Nov 17, 1921, that I last saw h alive on Nov. 16, 1921, and that death occurred, on the date stated above, at 2.30a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Coma

(duration) ✓ yrs. ✓ mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Shannon, M. D.

11/17/1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov. 19 1921
20 UNDERTAKER	ADDRESS
Geo. J. Smith	1200 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58662

CERTIFICATE OF DEATH.

43D 58662

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 N. Schroeder ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Collins Flood.

(Residence in Baltimore: No. 637 N. Schroeder St ST.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 27, 1871 (Month) (Day) (Year)

7-AGE, 49 yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... Saleslady

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel J. Flood.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Elizabeth A. Collins

13-BIRTHPLACE OF MOTHER (State or Country), Nashville, Tenn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizebeth A. Flood

(Address) 637 N. Schroeder St

15- Filed NOV 17 1921, 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 16, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1921, to Nov. 16 1921, that I saw her alive on Nov 16 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of lung

(Duration) ? yrs. mos. ds.

(Signed) Mabel Bell M. D.

Nov 17, 1921 (Address) 1320 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Nov. 19 1921

20-UNDERTAKER Geo J Smith

ADDRESS 1000 Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58663

CERTIFICATE OF DEATH.

X 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp. St. 18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Harrison

(a) RESIDENCE. No. N. & C. Hosp St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 17, '21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Phila. Pa

PARENTS

10 NAME OF FATHER Edgar Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Eliz. Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Monday Point Va

14 Informant Elizabeth Harrison (Address) Monday Point Va

15 Filed 19 Robert P. Harrison, Registrar

NOV 17 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20th, 1921, to Nov. 17th, 1921, that I last saw her alive on Nov 17th, 1921, and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows:

6 hr. Intestinal Intoxication

(duration) yrs. — mos. 28 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? —

(Signed) Israel Kreigler, M. D.

19 (Address) 1102 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 18 1921

20 UNDERTAKER George J Smith ADDRESS 1400 E Fayette

MAME should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 58664 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt Sinai Hosp

CITY OF BALTIMORE: (No.) 1403 Annapolis ave (St.) W 5 (Ward) 63

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Valentine

(a) RESIDENCE. No. 1403 Annapolis ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76		One	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 015
(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter
(c) Name of employer Not

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary Mt French.
(Address)

15 Filed . 19 Robert P. Harrison, Registrar
1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1921, to Nov 17, 1921, that I last saw him alive on Nov 16 1921, and that death occurred, on the date stated above, at 10 20 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans.
Senile

(duration) 1 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? age and

(Signed) Marshall Raymond V. Johnson, M. D.

. 19 (Address) 1 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 19 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 N. Fayette.

TION is very important. See instructions on back of certificates.

D 58665 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. General Hospital WARD) 70 100

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Arthur Watson

(Residence in Baltimore: No. 1923 Edmondson Ave. St.: 6 yrs., 11 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): single

6-DATE OF BIRTH, November 26, 1914
(Month) (Day) (Year)

7-AGE, 6 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Adam M. Watson

11-BIRTHPLACE OF FATHER (State or Country) Md.

12-MAIDEN NAME OF MOTHER Laura M. Sieger

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam M. Watson

(Address) 1923 Edmondson Ave.

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

V 17 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 15, 1921,
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry
(Inquest, autopsy or inquiry.)
find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Streptococcus sore throat, Carcinoma and Ludwigs angina

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Harrison M. D.
(Coroner.)

Nov. 16, 1921 (Address) 2552 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Md. Gen. Hosp. ....yrs. ....mos. 4 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

1923 Edmondson Ave.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Thomas Cemetery

DATE OF BURIAL, Nov. 18. 1921

20-UNDERTAKER Geo J Smith

ADDRESS 1000 E. Fayette St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58666

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 N. Fulton Ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Captain Wm. William A. Dixon

(a) RESIDENCE. NO. 1126 N. Fulton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie C. Dixon

6 DATE OF BIRTH (month, day, and year) Jan. 4th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain (Steamship) 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mathews Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Wickham Dixon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Cray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Mrs. Annie C. Dixon
(Address) 1126 N. Fulton Ave.

15 Filed NOV 17 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1920 to Nov 16 1921 that I last saw him alive on Nov 14 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Duration Over 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None Duration Over 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry C. Dixon M. D.

Nov 17. 1921 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Nov 19 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58667

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH Robt Garrett Hosp for Children REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Panna

(a) RESIDENCE. No. 615 W. North Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George H. Panna

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Lelia Lyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lelia Panna

(Address) 1103 Woodlawn St

15 NOV 18 1921 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1921, to Nov 16, 1921, that I last saw her alive on Nov 16, 1921, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) J. W. Clift, M. D.

11/16. 1921 (Address) 27 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov. 18th 1921
20 UNDERTAKER Mrs Thos John H. Penkala Son	ADDRESS 801 W Fayette St

mation should be carefully supplied. Age. Should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as to diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Intestinal Indigestion.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Cohen

D 58668

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-591

D 58668

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. 5 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Cohen

(a) RESIDENCE. No. 403 N. Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible].

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Frank Cohen
(Address) 403 N. Eden St

[illegible] NOV 18 1921 [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1921, to Nov. 17, 1921, that I last saw him alive on Nov. 17, 1921, and that death occurred, on the date stated above, at 4:03 P.m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis - Influenzal

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture and growth of B. influenzae

(Signed) Moses Seidman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale Cem.	Nov 16 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Baltimore St

I. B. mation should be carefully supplied. Age and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

58669

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D 58669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Eutaw Place ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie D. Taylor

(a) RESIDENCE NO. 1518 Eutaw Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Frank Taylor

6 DATE OF BIRTH (month, day, and year) May 30. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Lev. Sylvester

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Barbara Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lillian Lovard

(Address) 1702 Montpelier St

15 NOV 18 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1921, to Nov 17, 1921, that I last saw h[illegible] alive on Nov 17, 1921, and that death occurred, on the date stated above, at 1 10 P. M.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E W Lear M. D.

, 19 (Address) 1908 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	Nov 20 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Pleasant St.

mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Medical Cert

Spec.—1-10-21—M&T—1500 Blks.

Dr. Moore Ellwood & Gough

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58670

D 58670

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 270 S. East Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John X. Smith

(a) RESIDENCE No. 270 S. East Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Smith

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Producers 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Martin Wagner

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Conrad Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Kruck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Smyth (Address) 70 S. East Ave.

15 Filed NOV 18 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1920 to Nov 18 1921, that I last saw him alive on Nov 15 1921, and that death occurred, on the date stated above, at 2 45 P.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic parenchymatous nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sum of W.B.

(Signed) L. Smith, M. D.

, 19 (Address) 301 S Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cem.

DATE OF BURIAL Nov. 18, 21

20 UNDERTAKER H Sander Sons

ADDRESS 120 Park Ave

mation should be carefully supplied. AGE should be stated correctly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58671

CERTIFICATE OF DEATH.

15 D 58671

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Clinton Ave ST., 17 WARD)

2-FULL NAME Dorothy Rini

(a) RESIDENCE No. 626 Clinton ST., Ave 17 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov. 16. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Ferdinand Rini

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Clifford

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Ferdinand Rini
(Address) 626 Clinton Ave.

15 Filed NOV 18 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1921, to Nov 17, 1921, that I last saw h[illegible] alive on Nov 17, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows: Premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Placenta Praevia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. W. Heinmeyer, M. D.

11-17, 1921 (Address) 800 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 17 1921

20 UNDERTAKER William Cook

ADDRESS 5526 York

N. B.—WRITE PLAINLY, WITH INK. ALL ITEMS AND THE AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58672

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58672

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary Ann Loney.

(Residence in Baltimore: No. 2015 N St Paul St. St.; 50 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Don't Know. (Month) (Day), 1850 (Year)

7-AGE, 71 yrs. mon. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Uniontown Pa.

PARENTS.

10-NAME OF FATHER, Levi Gise.

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Mary Harbold.

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. Johnson

(Address) 2015 N. St Paul St.

15- NOV 18 1921 ROBERT J. FAIRER

Filed ....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 17th, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1921, to Nov. 17 1921, that I saw h[er] alive on Nov. 16 1921, and that death occurred, on the date stated above, at 10.35 a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Alcoholic

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Intestinal Infection

(Duration) 7 yrs. mos. da.

(Signed) J. Thomas Johnson M. D.

Nov 17, 1921. (Address) 1001 N. Eutaw Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park Cem | DATE OF BURIAL, Nov. 21, 1921

20-UNDERTAKER William Cook | ADDRESS 509 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Wheeler 2129 W. North

CERTIFICATE OF DEATH.

D 58673

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Wylie ave. ST.: 27 WARD)

119 D 58673
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Malone

(a) RESIDENCE. No. 2 Wylie Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None job

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, md

PARENTS

10 NAME OF FATHER Jas. J Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Marie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cal.

14 Informant Jas. J. Malone
(Address) 2 Wylie ave

15 NOV 18 1921 ROBERT I. GRAVES Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1921, to Nov 16, 1921, that I last saw h[e] alive on Nov 16, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Poison

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ... yrs. ... mos 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? none

What test confirmed diagnosis? General symptoms

(Signed) E Miles Wheeler, M. D.

, 19 (Address) 2129 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov 19, 1921
20 UNDERTAKER	ADDRESS
Wm Coop	507 E North Ave

mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition as far as physician knew.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58674

CERTIFICATE OF DEATH.

64 D 58674

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1800 Barclay ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael D. Burnett

(a) RESIDENCE. No. 1800 Barclay ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma J. Burnett.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83,			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Seaman 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Joseph P. Burnett.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Virginia

12 MAIDEN NAME OF MOTHER Caroline Patrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs. W. H. Van Hook 1800 Barclay St.

15 Filed NOV 18 1921 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1921, to Nov 17, 1921, that I last saw him alive on Nov 16, 1921, and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Watson, M. D.

(Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem — DATE OF BURIAL: Nov 19, 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58675

CERTIFICATE OF DEATH.

64 D 58675

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 E. North ave ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christine Bichy

(Residence in Baltimore: No. 413 E. North ave St.; 74 yrs., mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, Oct. (Month) 18 (Day), 1834 (Year)

7-AGE, 74 yrs. mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Michael Jacob.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Frisch.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Emma Bichy

(Address) 413 E North ave

15- Filed NOV 18 1921 ~~DOREY S [illegible]~~ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1921, to Nov. 16, 1921, that I saw her alive on Nov. 16, 1921, and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia 000

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Hugh Forsythe M. D.

Nov. 17, 1921. (Address) 424 E. North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Nov. 21, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION IS very important. See instructions on back of certificate.

Remarks

Probably terminal hemorrhage

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58676

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 422 N. Duncan ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Inf of. Barbara Jendrich

a) RESIDENCE. No. 422 N Duncan ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 15 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Barbara Jendrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Barbara Jendrich
(Address) 422 N Duncan St

15 NOV 18 1921 ROBERT J. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to Nov 15, 1921, that I last saw h[illegible] alive on Nov 15, 1921, and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Abram B Lennan, M. D.

11/16, 1921 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hopkins Place Cemetery	11/16/21
20 UNDERTAKER	ADDRESS

mation should be carefully supplied. And it should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58677

REGISTERED No. 78 D 58677

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 Baker ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry A S Saunders

(a) RESIDENCE NO. 723 Baker St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Agnes C Saunders

6 DATE OF BIRTH (month, day, and year) Oct 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Wm Saunders

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Simms

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Agnes Saunders
(Address) 723 Baker St

15 NOV 18 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 17 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-14-, 1921, to 11-17-, 1921, that I last saw him alive on 11-17-, 1921, and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

Cystitis

Sores of mouth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholic Cirrhosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 723 Baker

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm R. Dorkin, M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL Nov 20 1921

20 UNDERTAKER Harwood & Wright — ADDRESS 1364 W Mary

mation should be carefully supplied. AGE and
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia: Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis.

Spec.—1-10-21—M&T—1500 Bks.

D 58678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 58678

1-PLACE OF DEATH St. Vincents Infant Asylum

REGISTERED NO.

CITY OF BALTIMORE: (No. 1401 Division. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mc Gill

(a) RESIDENCE NO. 1401 Divisio st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 200

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ann McGill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St Vincents

(Address) 1401 Division st

Filed NOV 18 1921

BURIAL PERMIT Request

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1921, to Nov 16, 1921, that I last saw her alive on Nov 16, 1921, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus Postoperation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas Plaumier M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 18 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North Ave

mation should be carefully supplied. Any information which may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58679

D 58679

CERTIFICATE OF DEATH.

REGISTERED NO. 138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital WARD)

2-FULL NAME Cora McGilley

(a) RESIDENCE NO. W. Vincents Inf Asylum WARD Richmond Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	N.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant St Vincents
(Address) 1401 Division St

15 Filed NOV 18 1921 ROBERT J. KRAUTER Registrar

Burial Permit Oleeb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1921, to Nov. 15, 1921.

that I last saw her alive on Nov. 15, 1921

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy
Eclampsia

(duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 4 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov. 15-1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag -

(Signed) W.C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 18 1921
20 UNDERTAKER	ADDRESS
Watkins Fahey & Sons	1827 N Northern

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58680

CERTIFICATE OF DEATH.

91 D 58680

REGISTERED NO.

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE: (No. 1401 Division St. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Ward

(a) RESIDENCE. NO. 1401 Division St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15. 1921

7 AGE — Years: — Months: 3 Days: 29 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Catonsville Md.

PARENTS

10 NAME OF FATHER: William Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: St Vincents
(Address) 1401 Division St

15 Filed NOV 18 1921 ROBERT J. BRAUTEN Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1921, to Nov 13, 1921, that I last saw h[illegible] alive on Nov 13, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows: OVER

Bronchio Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Chas O Flautten, M. D.

Nov 18 1921 (Address) 1504 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 18 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 N Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58681

CERTIFICATE OF DEATH.

X 79

D 58681

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Louisa P. Minis

(a) RESIDENCE NO. Savannah, Ga. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. J. Florance Minis

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	69	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 137

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Savannah, Ga

PARENTS

10 NAME OF FATHER Geo. Gilmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car.

12 MAIDEN NAME OF MOTHER Louisa Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington, Ga.

14 Informant J. F. Minis (Address) 24 Gaston St. W. Savannah, Ga

15 Filed NOV 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to Nov 16, 1921, that I last saw h alive on Nov 16, 1921, and that death occurred, on the date stated above, at 5-09 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Myocardial Insufficiency

(duration) 10 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2-3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E E Duncan, M. D.

11/16, 1921 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savannah Ga.	11-18 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Sons Co	McCulloch Orchard

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24 14—M. & T.—2000 Bks.

D 58682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Charles St. Ave. ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Joseph Griffin

(Residence in Baltimore: No. Notre Dame of Maryland, Charles St. Ave. (If non-resident, give usual residence.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, January 24, 1859 (Month) (Day) (Year)

7-AGE, 62 yrs. 4 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clergyman & Prof.
(b) General nature of Industry, business, or establishment in which employed (or employer): Prof. of Chemistry

9-BIRTHPLACE, (State or Country), New York

PARENTS:

10-NAME OF FATHER, Jeremiah Griffin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Devine

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister M. Philemon

(Address) Charles St. Ave.

15-NOV 18 1921 Filed....., 191.... BOYER & KRAUTH Local Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 16, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Nov 16 1921, that I saw h[im] alive on Nov 16 1921, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

Arteriosclerosis (Duration) yrs. mos. ds.

(Signed) Clan Dominic M. D.

Nov 16, 1921. (Address) 4706 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenlawn (Private Cem) — DATE OF BURIAL, Nov 19, 1921

20-UNDERTAKER Frank A. Finke — ADDRESS 915 N. Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58683

CERTIFICATE OF DEATH.

79 D 58683

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1821 N. Port ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Etchberger

(a) RESIDENCE. No. 1821 N. Port ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1905

7 AGE: Years 16 Months 4 Days 1 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Office boy
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Roy S. Etchberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Johanna Guy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Roy S. Etchberger
(Address) 1821 N. Port St

15 Filed NOV 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1921, to Nov 16, 1921,
that I last saw h. alive on Nov 16, 1921,
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Heart Disease
Aortic Insufficiency.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism Chronic

(duration) 7 yrs. ago mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Akehurst M. D.

(Address) 1936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Nov 19 1921

20 UNDERTAKER: Burkert & Zickler — ADDRESS 1739 Eager

mation should be carefully supplied. Exact statement of
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58684

CERTIFICATE OF DEATH.

40 D 58684

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 367 N. Preston ST., 11 WARD)

2-FULL NAME Jennie Brooks

(a) RESIDENCE NO. 367 N. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife 37

(b) General nature of industry, business, or establishment in which employed (or employer): Home keep

(c) Name of employer: live in Balt- 39 years

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: James Brooks
(Address) 367 Preston St

15 Filed NOV 18 1927 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1927, to Nov. 16, 1927, that I last saw h Alive on Nov. 16, 1927, and that death occurred, on the date stated above, at 6 8 m.

The CAUSE OF DEATH* was as follows:

Pernicious Exhaustion

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma (duration) yrs. 6 mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H Jenkins M. D.

19 (Address) 1019 Dawson Hillen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int- Aurelian Cem

DATE OF BURIAL: Nov 20 1927

20 UNDERTAKER: Mrs Roker-A Elliot

ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58685 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58685

CERTIFICATE OF DEATH.

109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 S Carey ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs A Bell

(a) RESIDENCE. NO. 1114 S Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Bell

6 DATE OF BIRTH (month, day, and year): Feb. 29-1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer): Produce Dealer

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: William H Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Charles Bell 1114 S Carey St

Filed NOV 18 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to Nov 15, 1921, that I last saw h— alive on Nov 15, 1921, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
non Tuberculosis.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (secondary) Senile Bronchitis & Arteriosclerosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen D Bain, M. D.

, 19 (Address) 1119 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov. 18 1921
20 UNDERTAKER	ADDRESS
George L Schwab	2101 Eutaw Ave

mation should be carefully supplied. Any blanks
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

ay be properly classified. Exact statement of OCCUPA-
ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

Attley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58686

D-25807 58686

CERTIFICATE OF DEATH.

REGISTERED NO. 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) JOHNS HOPKINS HOSPITAL ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Attley

(a) RESIDENCE. NO. 1334 Forest St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~Female~~	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marshall

6 DATE OF BIRTH (month, day, and year) Dec. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Floyd Kinnar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed NOV 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-15, 1921, to 11-16, 1921, that I last saw h[illegible] alive on 11-16, 1921, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Tetanus, from splinter

(duration) yrs. mos. 4 ds.

(over)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Nov. 15, 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Boulden Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov. 19 '21
20 UNDERTAKER	ADDRESS
Chris. H. Johnson	446 N. Caroline

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58687

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58687

CERTIFICATE OF DEATH.

X 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 220 E. Twenty Fifth ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Albert Shaw

(a) RESIDENCE. No. 220 E. Twenty Fifth ST., ... WARD. Louisville Ky.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Emma Shaw

6 DATE OF BIRTH (month, day, and year) Jan. 24th 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Theatre Manager

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Morpeth Ontario

PARENTS

10 NAME OF FATHER C. A. Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Shaw (Address) 220 E. Twenty-Fifth

NOV 18 1921

[illegible] KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1921, to Nov 17th, 1921, that I last saw him alive on Nov 17th, 1921, and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 220 E 25th St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. Garthorne, M. D.

, 19 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louisville Kentucky	Nov. 19th 1921
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton Md.

mation should be carefully supplied. Ar... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58688

CERTIFICATE OF DEATH.

105 D 58688

D 58688
1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE (No. 821 So. Milton Ave ST.: 1. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPH BLACHOWICZ,

(a) RESIDENCE. No. 821 So. Milton Ave ST., I. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Widowed,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hedwig Blachowicz,

6 DATE OF BIRTH (month, day, and year) Unknown 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer, 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER John Blachowicz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mary Blachowicz. 821 So. Milton Ave

15 Filed NOV 18 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 16, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 1924. to Nov 17 1924.

that I last saw h[illegible] alive on " 17 1924.

and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

General Debility Duration

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Dysentery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Wanless, M. D.

1924 (Address) 1411 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Nov. 19. 1921.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic diarrhoea
due to gastro intestinal
trouble. Not bacillary
dysentery.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58689 ✓ 1720 58689

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S. Ann ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie E. Kelly

(a) RESIDENCE NO. 106 S. Ann ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Kelly

6 DATE OF BIRTH (month, day, and year) June 4-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn (State or country) N. Y.

PARENTS

10 NAME OF FATHER Peter Heenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Mary A. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Thos. Kelly (Address) 106 S. Ann St.

15 Filed ..., 19... Registrar

NOV 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 1, ..., 1921, to Nov. 16, ..., 1921.

that I last saw h[illegible] alive on Nov. 15, ..., 1921.

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Pyemia

(duration) ... yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyo-nephrosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Eugene L. Pennington, M. D.

Nov. 17, 1921 (Address) Ten Hills — Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. — DATE OF BURIAL 11-19-1921

20 UNDERTAKER J. A. Moran — ADDRESS 3000 E. Balto.

N.B.—WRITE LEGIBLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be CAUSE OF DEATH is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58690 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58690

CERTIFICATE OF DEATH.

REGISTERED NO. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Keene

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 22 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer): Drugs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER William Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Catherine Bimpard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Records of Mt Hope Retreat
(Address): Mt Hope Md.

Filed NOV 18 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14th 1909 to Nov 15 1921.

that I last saw him alive on Nov 13 1921,

and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Suddenly — Acute Cardiac Dilatation — Death abt 15 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paranoia

(duration) 12 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Nov 16 1921 (Address) Mt Hope Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	11-19- 1921
20 UNDERTAKER J. G. Moran	ADDRESS 5000 E Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-8-19—H. P. Co.—1000 Blks.

D 58691

D 58691 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. ...

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Maryland General Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Ward.

(a) RESIDENCE. NO. Towson Md. ST., WARD. Towson Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? 3 yrs. 7 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James C. Ward.

6 DATE OF BIRTH (month, day, and year) April 14. 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52.	7	4.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Slade.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant James C. Ward
(Address) Towson Md.

15 Filed Nov 18 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1921, to Nov 18, 1921, that I last saw h[illegible] alive on Nov 18, 1921 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis
Subacute pancreatitis.

(duration) yrs. 4. mos. ds.

CONTRIBUTORY (Secondary) Acidosis - Cardiac Failure (duration) yrs. mos. 4. ds.

18 Where was disease contracted if not at place of death? Towson. Md

Did an operation precede death? Yes Date of Nov. 12. 1921

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) John W Whitaker, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marie Cem Towson.	Nov 21 1921
20 UNDERTAKER	ADDRESS
J. Stuart Burns Sons	Towson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 58692 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Md. Gen. Hosp., ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred R. Wier

(Residence in Baltimore: No. Ruxton, Md. St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, Dec. 1 (Month) (Day), 1894 (Year)

7-AGE, 27 yrs. mos. da. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: R.R. Clerk
(h) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, James Wier

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Edna May Wyatt

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Wier

(Address) Ruxton, Md

15- Robert P. Harrison, Registrar.

1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 16 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull
Struck by an automobile (unknown)
Hallowed, (Duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) auto accident
(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Nov. 16, 1921 (Address) 2802 Effingham Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Md. Gen. Hosp. in the city of death yrs. mos. 1 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? Falls Road, two miles from Washington Ave,

Former or usual residence Ruxton, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Prospect Hill	Nov. 18 1921
20-UNDERTAKER John Burns Son	ADDRESS Towson Md

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18

Spec. 6-1-19 H. P. Co.—1000 Bks.

D 58693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58693

CERTIFICATE OF DEATH.

15205 11

117

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rabenau

(a) RESIDENCE. NO. 1501 N Chapel St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 7th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adolph Rabenau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Goodwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed NOV 18 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15th, 1921, to Nov. 17th, 1921, that I last saw h[illegible] alive on Nov. 17th, 1921, and that death occurred, on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis (primary)

NOV

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? no Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? Culture probably pneumococcus

(Signed) Horace G. Stewart, M. D.

11/17, 1921. (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 19th 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son	811 N Wolfe

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history.
Cause of peritonitis
unknown.

D 58694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 23 175 003

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Wallace.(C)

(Residence in Baltimore: No. 1125 S. Sharp St. St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, February 28th. 1893, 1
(Month) (Day) (Year)

7-AGE, 28 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, Lemuel Wallace)C)

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Annie M. Boots.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Wallace.(C) wife.

(Address) 1125 S. Sharp St.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

NOV 18 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 16th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries.
Accidentally run over by a car of the B. Md. R. R. Co.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) ..... M. D.
(Coroner.)

Nov. 17th. 1921 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? Port Covington, B. Md. R. R. Pier.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Parkers Creek. DATE OF BURIAL, Nov. 19 1921

20-UNDERTAKER Calvert Co Md ADDRESS 142 John H. Tradwins Ostend St

D 58695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1639 Belt Ave. ST.) WARD)

REGISTERED No. C 45

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Simon Keefer.

(Residence in Baltimore: No. Carroll Co.Md. St.; yrs. --- mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, August 18th. 1847., 1

(Month) (Day) (Year)

7-AGE. 74 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Carroll Co.Md.

PARENTS.

10-NAME OF FATHER, Joseph Keefer.

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co.Md.

12-MAIDEN NAME OF MOTHER Margaret Coppersmith.

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co.Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Keefer. (wife)

(Address) 1639 Belt Ave.

15-

Robert P. Harrison,

Filed....., 191.....

AV 1 91921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 16th. 1921., 191...

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of the bladder.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D. (Coroner.)

Nov. 17th, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Carroll Co.Md.

Former or usual residence Carroll Co.Md.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Baust Cemetery Md. Carroll Co.	Nov. 19, 1921.
20-UNDERTAKER C. M. Waltz.	ADDRESS Hufield, Md.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58696

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3605 Springdale Ave ST.) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. D. Merryman

(Residence in Baltimore: No. 3605 Springdale Ave, St.; 77 yrs, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, July 1, 1844
(Month) (Day) (Year)

7-AGE, 77 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Dr.
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Laundry Merchant)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas. Merryman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Ann Dove

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Hammond Merryman

(Address) 3804 Walpurgis Ave

15- Robert P Harrison,

Filed ....., 191.....

1921 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jurors find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nyaine Heart disease

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) Chr. Intes. Nephritis

(Duration) 2 yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Nov. 17, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 19..., 1921

20-UNDERTAKER John O'Mitchell ADDRESS 1201 N. Fayette St.

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58697 ✓ D 58697

D 58697

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Bowser

(a) RESIDENCE. NO. 206 Poppleton St. ST., WARD.

(Usual place of abode) unknown (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) , 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore, Maryland

PARENTS

10 NAME OF FATHER Henry Bowser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sally Goldsborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Maryland

11 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed Robert P Harrison, Registrar

1 9 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from November 15 1921 to November 16 1921 that I last saw her alive on November 15 1921 and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency 6 (?) mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

11/16/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 19 1921
20 UNDERTAKER	ADDRESS
Dent Corbett	City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 58698

D 58698

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 158 W. Hamburg St.: 23 Ward)

2-FULL NAME Charles Martin

(a) RESIDENCE. No. 158 W. Hamburg St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Minnie Martin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 33				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster house attendant

(c) Name of employer Wm. McDonald

9 BIRTHPLACE (city or town) (State or country) Elizabeth City N. C.

PARENTS

10 NAME OF FATHER Charles Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elizabeth City N. C.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Minnie Martin Wife (Address) 158 W. Hamburg St.

15 Filed NOV 19 1921 Robert F. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1921, to Nov. 17, 1921, that I last saw h[illegible] alive on Nov. 17, 1921, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. L. Shelton, M. D.

Nov. 19 21 (Address) 123 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elizabeth City N. C.

DATE OF BURIAL: Nov 19 1921

20 UNDERTAKER: W. L. Brown and Son

ADDRESS: 1058 W. Monty

Chesterfield 5 8 6 nu mortons

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58699

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 N Schroeder ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Clarke.

(a) RESIDENCE. NO. 7 N Schroeder ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — James Clarke.

6 DATE OF BIRTH (month, day, and year) Unknown. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63.				

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work — House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Patrick Kiaen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann McCluskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Molly Young. (Address) 7 N Schroeder St-ff.

15 Filed 1 9 1921 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/ 1921

17

I HEREBY CERTIFY, That I attended deceased from 11/8 , 19 21 , to 11/18/21 , 19 ,

that I last saw h alive on 11/18/21 , 19 ,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Dil B + phthis

Pulmol Tuberc.

(duration) 2 months yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Feeney, M. D.

Nov 21, 1921 (Address) 910 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Nov 21st 1921
20 UNDERTAKER	ADDRESS
J. J. Cowan & Son	901 Hollins St

mation should be carefully supplied. Avoid abbreviations. Write plainly in ink. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58700

CERTIFICATE OF DEATH.

152

D 58700

REGISTERED NO.

1-PLACE OF DEATH University Hospital
Lanford & Greene
CITY OF BALTIMORE: NO. ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hudgins

(a) RESIDENCE. NO. 1703 W Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1 hr	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Mc Kinley Sewell
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Beatrice Hudgins
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Beatrice Hudgins
(Address) 1703 W Franklin St.

15 Filed NOV 19 1921 Robert P. Harrison Registrar

Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1921, to Nov 17, 1921, that I last saw him alive on Nov 17, 1921, and that death occurred, on the date stated above, at 7 05 A m.

The CAUSE OF DEATH* was as follows:

Intracranial pressure subsequent to prolonged labor.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.
11-17 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	ADDRESS
20 UNDERTAKER	NOV 18 1921

Commissioner of Health,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58701

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Leak

(a) RESIDENCE. NO. 237 S. Dallas st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Samuel Leak

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Josephine Hannah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records
(Address) M.T.H.

15 Filed 1921 Robert P. Hartigan Registrar
By ..... Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1921, to Nov. 15, 1921, that I last saw him alive on Nov. 15, 1921, and that death occurred, on the date stated above, at 10.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglacee M. D.

11-15-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Nov 16 1921

20 UNDERTAKER Commissioner Health. ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Dies)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58702

D 58702

CERTIFICATE OF DEATH.

REGISTERED NO. C 1329

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3327 Chestnut Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Noah Dyer

(Residence in Baltimore: No. 3327 Chestnut Ave St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Aug. (Month) 15 (Day), 1852 (Year)

7-AGE 69 yrs. 4 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Huckster
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Carroll Co Md

PARENTS.

10-NAME OF FATHER, Asked Not Known

11-BIRTHPLACE OF FATHER (State or Country) Asked Not Known

12-MAIDEN NAME OF MOTHER Effie Shuster

13-BIRTHPLACE OF MOTHER (State or Country) Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carol K. Dyer

(Address) 3327 E Chestnut Ave

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1921, to Nov. 1921, that I saw him alive on Nov. 17, 1921, and that death occurred, on the date stated above, at 8 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) 2 yrs. ....mos. ....ds.

(Signed) H. H. Machen M. D.

Nov. 19, 1921. (Address) 4119 Falls Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Nov. 21, 1921

20-UNDERTAKER H. S. Marshall ADDRESS 3339 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Darry Fountleroy)

D 58703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 420 Pearl st ST.: 17 WARD) REGISTERED No. C 78

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Darry Fountleroy

(Residence in Baltimore: No. 540 W Mulberry st St.: yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1871 (Year)

7-AGE, 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 100
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Johnson

(Address) 540 W. Mulberry

15- Robert P. Harrison,

Feb 1921, 191.. Special Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~Autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, ~~Autopsy~~ or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs mos. ds.

CONTRIBUTORY (Secondary) Pott Disease

(Duration) yrs. 4 mos. ds.

(Signed) W K Gonce M. D. (Coroner.)

11-19, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, W Mulberry Cem DATE OF BURIAL, Nov 19, 1921

20-UNDERTAKER Saml H Hemsley ADDRESS 57 N Bond

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 58704

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2729 N. Calvert ST.: 17 WARD)

2-FULL NAME Mary Adelaide Morton

(a) RESIDENCE. NO. 2729 N. Calvert ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White American	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 Yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George C. Morton

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ann Paschal (Morton)

13 BIRTHPLACE OF MOTHER (city or town) New Orleans
(State or country)

14 Informant Sue C. Morton Jr.
(Address) 11 E. Chase St.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1921, to Nov. 18, 1921, that I last saw h[illegible] alive on Nov. 18, 1921, and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteri-sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clarke, M. D.

Nov. 19 21 (Address) 20 Todd Bldg. Clay & Read Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 21 21
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Sons Co	Orchard & Caroline

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

(Sann)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58705

CERTIFICATE OF DEATH.

15 V D 58705

REGISTERED NO.

1-PLACE OF DEATH West End Maternity

CITY OF BALTIMORE: (No.) 17 N. Calhoun ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sann

(a) RESIDENCE NO. West End Maternity ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 12-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
—	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ddo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Henry Sann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Helen Dilley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John Henry Sann

(Address) Franklin Ave & Woodlawn Ave

15 Filed 1921, 19 Robert P. Harrison, Registrar

Social Service Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1921

17

I HEREBY CERTIFY, That I attended deceased from 11-12, 1921, to 11-17, 1921,

that I last saw him alive on 17, 1921,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Injury in birth due to a face presentation and long labor.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General convulsions & Intermittent atalepsis

Pulmonary edema (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Union Labor

Did an operation precede death? Yes (Version) Date of 11/12/21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Durand Dunn Mode M. D.

11-18-1921 (Address) 103 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int. Carmel Cem. DATE OF BURIAL Nov. 19 1921

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 724 Cider Alley (ST.) 4 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Fletcher

(a) RESIDENCE. NO. 724 Cider alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 12 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos Fletcher
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.
12 MAIDEN NAME OF MOTHER - Thomas -
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Gertrude Fletcher
(Address) Robert 724 Eastwood

15 Filed NOV 19 1921 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Nov 16, 1921, that I last saw him alive on Nov 16, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis -
(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage
(duration) yrs. mos. 40 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Gustav Pohlman, M. D.

, 19 (Address) 256 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 20 1921
20 UNDERTAKER	ADDRESS
N Maurice Rouston	2301 N Gilmor

mation should be carefully supplied. Are should be given. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58707

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58707

CERTIFICATE OF DEATH.

92-120 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Druid Hill Ave ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. David M West

(a) RESIDENCE. NO. 2059 Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth West

6 DATE OF BIRTH (month, day, and year): Aug. 3-1854

7 AGE: Years 67 | Months 3 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman (Teacher) School

(b) General nature of industry, business, or establishment in which employed (or employer): Race track Pimlico

(c) Name of employer: Jos Brennen

9 BIRTHPLACE (city or town) (State or country): Grantsville West Va.

PARENTS

10 NAME OF FATHER: Stephen M. West

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Va. Monongalia Co

12 MAIDEN NAME OF MOTHER: Mariesa Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wadestown Monongalia Co.

14 Informant: Mrs A E. Brodgrace
(Address) 208 N Mulberry

15 Filed . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

11 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 19 21 to Nov 18 19 21, that I last saw h alive on Nov 18 19 21, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia
fever

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) L. B. Evans, M. D.

. 19 (Address) 411 N. Greene St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Nov 21 1921

20 UNDERTAKER: W M Routson — ADDRESS: 230 N. Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis
for years.
Adynamic pneumonia
3 days.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr. Norbert Nestach

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58708

CERTIFICATE OF DEATH.

79 D 58708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2621 Lehman (St.) 20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Tsoras Tivis

(a) RESIDENCE. No. 2621 Lehman St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Tivis

6 DATE OF BIRTH (month, day, and year) Jan 22 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Streich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma J. Deems

13 BIRTHPLACE OF MOTHER (city or town) (State or country) American

14 Informant Wm Tivis (Address) 26 N Lehman

15 Filed 1921 Robert P Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 16, 1921, that I last saw h[illegible] alive on Nov 16, 1921, and that death occurred, on the date stated above, at 11 30 p m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis 0 0 0

Eddlordetis

(duration) Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert C Nyburt, M. D.

Nov 18, 1921 (Address) 2157 Walbrook ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 19 1921
20 UNDERTAKER	ADDRESS
F B Weppert	2336 Fredk ave

MAKE ONE ENTRY ONLY. If UNKNOWN, STATE SO. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58709

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Harmonson Ave.)

REGISTERED NO.....

CITY OF BALTIMORE: (No. 306 Harmonson ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Dobler

(a) RESIDENCE. No. 306 Harmonson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Meth	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Nov 18/21

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. J. Dobler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Anna V. Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm J. Dobler
(Address) 306 Harmonson St

15 Filed 1921 Robert P. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 19, 1921, that I last saw h alive on Nov 18, 1921, and that death occurred, on the date stated above, at 6.a. m.

The CAUSE OF DEATH* was as follows:

Lock Development 6 hr
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn M. D.

11/19 1921 (Address) 2027 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
F. B. Holy Rosary cemetery	Nov 19 1921
20 UNDERTAKER	ADDRESS
F. B. Thippard	2236 Fred'k Ave

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58710

CERTIFICATE OF DEATH.

X 120

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital St.: 4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Mays.

(a) RESIDENCE. No. 234 Balto. ave St Helena Md St., Ward. St. Helena Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

3 Boys St Helena

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Mary Mays.

6 DATE OF BIRTH (month, day, and year): Aug 3, 1852

7 AGE: Years 69 Months 3 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): Bethelehem Steel

(c) Name of employer: Co. Ship Yard

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: James Mays.

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Grace —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant: Mary A. Mays

(Address): 234 E Balto Ave St Helena

15 Filed: Nov 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1921, to Nov. 15, 1921, that I last saw him alive on Nov 15, 1921, and that death occurred, on the date stated above, at 11:05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis and cardiac decompensation

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? ?

What test confirmed diagnosis? Signs & Symptoms

(Signed) John C. Brown, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Nov 19 1921
20 UNDERTAKER	**ADDRESS**
Lilly & Zeller	403 S. Wolfe St

That it may be properly classified. Exact statement of OCCUPATION should be furnished. Supply all items. Write plainly. Use ink. Do not abbreviate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58711 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58711

CERTIFICATE OF DEATH.

13

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N. Castle ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Kirchner.

(a) RESIDENCE NO. 613 N. Castle ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kunigunda Kirchner

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinetmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Kunigunda Kirchner (Address) 613 N. Castle St

15 Filed Nov 19 1921 E. F. Farrell Registrar

Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14th 1921 to Nov 17th 1921, that I last saw him alive on Nov 16th 1921, and that death occurred, on the date stated above, at 6 45 a. m.

The CAUSE OF DEATH* was as follows:

Multiple Neuritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cystitis,

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Stoner M. D.

Nov 18, 1921 (Address) 1501 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 20 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeller	403 S. Wolfe St.

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58712

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D 58712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Mueller.

(a) RESIDENCE. No. 3314 Foster Ave. ST. 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Adelaide Mueller.

6 DATE OF BIRTH (month, day, and year): June 4th

7 AGE: Years 48 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry A. Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Elizabeth Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: B. Adelaide Mueller.

(Address) 3314 Foster Ave.

15 Filed 1921, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 1921, to Nov 17 1921, that I last saw h live on Nov 17 1921, and that death occurred, on the date stated above, at 11.55 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes mellitus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic + Blood

(Signed) Jas. Hemmeter, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Nov. 22nd 1921

20 UNDERTAKER: Lilly + Zeiler

ADDRESS: Hasewood Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. (Williams)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58713

D 58713

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 N. Washington St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ball.

(a) RESIDENCE. NO. 1205 N Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Ball

6 DATE OF BIRTH (month, day, and year) Dont Know 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Minnie Ball (Address) 1205 N Washington

15 Filed Nov 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1921 to Nov 18 1921, that I last saw him alive on Nov 17 1921, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart.

(duration) yrs. 3 mos. - ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W -

Did an operation precede death? W Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony Francis M. D.

(Address) 1417 W Fay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL Nov 21 1921

20 UNDERTAKER Lodge & Timmis

ADDRESS 1 N. Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V 1 # 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58714

CERTIFICATE OF DEATH.

78 D 58714

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 Lauretta Ave St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R Carr

(a) RESIDENCE. NO. 2406 Lauretta Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Maried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys Carr

6 DATE OF BIRTH (month, day, and year) Mar 17-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	8	1	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John F. Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mollie McGrann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas Balto Md

14 Informant Mollie Carr (Address) 2406 Lauretta Ave

15 Filed NOV 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to Nov 18, 1921, that I last saw h[illegible] alive on Nov 17, 1921, and that death occurred, on the date stated above, at 6.35A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 1 yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Buck M. D.

1921 (Address) 1318 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL Nov 21 19

20 UNDERTAKER [illegible] ADDRESS [illegible]

William Cook 502 E Nath

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and State TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58715

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Division ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nanni Thomas

(Residence in Baltimore: No. 1602 Division St

St.; ..... yrs., ... mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Sgle

6-DATE OF BIRTH, 11 (Month) 16 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John Thomas

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Lyda Brown

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Thomas

(Address) 1602 Division St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 18 (Day), 1921 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 1921, to Nov. 18 1921, that I saw her alive on Nov. 18 1921, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows: Congenital Debility - Prematurity

Contributed (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. Garland Churchill M. D.

Nov 19, 1921. (Address) 1534 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cemetery	Nov 19 1921
20-UNDERTAKER	ADDRESS
John H Toadvine	142 N Stricker St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 58716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. St.: 11 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LOUISE JOHNSON

(a) RESIDENCE. No. 11 W. LAFAYETTE ST AVE Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTIMORE MD.

PARENTS

10 NAME OF FATHER ROBERT JOHNSON

11 BIRTHPLACE OF FATHER (city or town) (State or country) BALTIMORE MD.

12 MAIDEN NAME OF MOTHER VIRGINIA FOUKES

13 BIRTHPLACE OF MOTHER (city or town) (State or country) BERRFELL Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed Nov 19 19 Robert P. Harrison, Registrar

Nov 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV. 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 22 , 19 21 , to Nov 17 , 19 21 ,

that I last saw her alive on Nov. 17 , 19 21 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. McDaniel, M. D.

, 19 (Address) JHH. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 19 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1235 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58717

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58717

CERTIFICATE OF DEATH.

X 74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William J. Kenan

(a) RESIDENCE. No. Burgoon Ohio ST., WARD. Burgoon, Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred . yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 8th 1916

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child DD

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John P Kenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Clara M. Foreman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed . 19 Robert P. Harrison, Registrar

NOV 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14th, 1921, to Nov. 18th, 1921, that I last saw him alive on Nov. 18th, 1921, and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? yes Date of 11/18/21

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy & Operation

(Signed) Jay Mc Lean, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fremont Ohio

DATE OF BURIAL Nov. 18 1921

20 UNDERTAKER William G. Schaeffer

ADDRESS 186 Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58718

CERTIFICATE OF DEATH.

1-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Rodgers

(a) RESIDENCE. NO. 2322 Cambridge ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 10 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry C Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Margaret Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Henry C Rodgers 2322 Cambridge St

Robert F. Harrison, Registrar

11 9 1921 .19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7 1921, to Nov. 19 1921, that I last saw he/she alive on November 19 1921, and that death occurred, on the date stated above, at 3:50 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Typhoid Fever

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? +Widal + Blood Culture

(Signed) Frank C. Marino, M. D.

(Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks	Nov 22 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 58719 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58719

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 S Duncan ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Polek

(a) RESIDENCE NO. 522 S Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 11 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ignatius Polek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rozalia Bardkiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ignatius Polek (Address) 522 S Duncan St

15 Nov 21 1921 Robert [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1921, to Nov 19, 1921.

that I last saw h alive on Nov 19, 1921,

and that death occurred, on the date stated above, at 9308 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 21 1921
20 UNDERTAKER	ADDRESS
John Weber	1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

19 1921

58720 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓58720

D 58720
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

157 D 58720
REGISTERED NO. C

CITY OF BALTIMORE (No. Dolfield Ave, Near Fremont St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Dawson

(Residence in Baltimore: No. 310 W. Lanvale St.

Daily Knows St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Daily Know

6-DATE OF BIRTH, October, 1856
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer). (General)

9-BIRTHPLACE, (State or Country), Daily Know

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. W. Dish Police

(Address) Balto. City

15- FILED NOV 20 1921 BUREAU OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov. 19, 1921 (Address) 2802 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Detroit Michigan	Nov 17 1921
20-UNDERTAKER David Easton	ADDRESS 916 Park Ave

U. S. Bureau of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58721

CERTIFICATE OF DEATH.

D 58721

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Ridler & Stillmans ST.: 15 WARD)

2-FULL NAME Howard F. Woolf

(a) RESIDENCE. No. 1802 Rosedale Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager.

(b) General nature of industry, business, or establishment in which employed (or employer) Sandwich Rooms

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Millard Woolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Florence Maynor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Lula. My Woolf
(Address) 1802 Rosedale Ave

15 Filed NOV 20 1921 BOARD OF HEALTH

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1921, to Nov 18, 1921,

that I last saw h.i. alive on Nov 18, 1921,

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Emphysema - right side

6 (duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) General Sepsis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 1802 Rosedale Ave.

Did an operation precede death? yes Date of Nov. 12. 1921

Was there an autopsy? no

What test confirmed diagnosis? The operation &c

(Signed) H H Stansbury, M. D.

. 19 (Address) 714 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 21 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for drainage. Not tuberculous. No further history. Cause of sepsis unknown

D 58722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 58722
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Franklin Square Hospital WARD)

2-FULL NAME Bernard English

(Residence in Baltimore: No. 2883 Kirkley Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April (Month) 13 (Day), 1917 (Year)

7-AGE, 4 yrs. 7 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John A English

11-BIRTHPLACE OF FATHER (State or Country) Liverpool England

12-MAIDEN NAME OF MOTHER Elsie V. Becker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A English

(Address) 2883 Kirkley Ave

15-

NOV 20 1921 191.. ROBERT J KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Burns
accident
(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Shock.
(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Edwin Bladel M. D.
(Coroner.)
Nov 19 1921 (Address) 173 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Park — DATE OF BURIAL, Nov 22 1921

20-UNDERTAKER William Cook — ADDRESS 5026 Northern Ave

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58723

CERTIFICATE OF DEATH.

124 D 58723

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2418 Callow Ave ST. 13 WARD)

2-FULL NAME Mrs Sallie Jandorf

(a) RESIDENCE. No. 2418 Callow Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruben Jandorf

6 DATE OF BIRTH (month, day, and year) Jan 10, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Gerson Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Francis Stonehouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry R Jandorf
(Address) 2001 Eutaw Pl

15 NOV 20 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1921, to Nov 18, 1924, that I last saw him alive on Nov 17, 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Mass of Abdomen

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Cyclitis Old age

(duration) yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam by Dr. A. Offranthaus

(Signed) L. P. A. Offranthaus, M. D.

, 19 (Address) 204-6 Professional Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Sholom	Nov 20 1924
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58724

CERTIFICATE OF DEATH.

D 58724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Twelfth St.) (ST. 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myal Josephine Eklund

(a) RESIDENCE. NO. 417 S. Twelfth ST. 76 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 4 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4th 1913

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attendant at

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Daniel H. Eklund

11 BIRTHPLACE OF FATHER (city or town) Laurel Md.
(State or country)

12 MAIDEN NAME OF MOTHER Florence S. Carey

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country)

14 Informant Daniel H. Eklund
(Address) 417 S Twelfth St

15 Filed NOV 20 1921, 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1921, to Nov 19, 1921, that I last saw h Ev alive on Nov 19, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) [illegible] M. D.

(Address) 3320 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 20 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S Wolfe

MEDICAL CERTIFICATE OF DEATH should be carefully supplied. ALL should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58725

CERTIFICATE OF DEATH.

119 D 58725

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Myrtle Ave ~~St.~~ 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Johnson

(a) RESIDENCE NO. 1306 Myrtle Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jack Johnson

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: 52 Years Months Days — If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Julius Hargrove
(Address): 1306 Myrtle Ave

15 Filed ..... 19 .....

Registrar

NOV 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 12th. 1921. to Nov 17th. 1921.
that I last saw h[illegible] alive on Nov. 16th. 1921.
and that death occurred, on the date stated above, at 7 PM m.
The CAUSE OF DEATH* was as follows: Acute Nephritis

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria.

(Signed) A. Fu Ellis, M. D.

11/18. 1921 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 20 1921

20 UNDERTAKER: David Ellis — ADDRESS: 916 Fa

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect. Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
No other abnormal
condition than
acute nephritis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58726

CERTIFICATE OF DEATH.

D 58726

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli Bailey

(a) RESIDENCE. No. 318 E 20½ St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 10 yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Eli Bailey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Elizabeth Holmes. (Address) 318 E. 20½ St.

15 Filed NOV 20 1921 19 ROBERT J. GRAFTON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1921, to Nov 18, 1921, that I last saw h.. alive on Nov. 18th, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Collapse of Lungs

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical diagnosis

(Signed) W. H. Hall, M. D.

Nov 19th 1921 (Address) 426 E 22 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Nov 20 1921
20 UNDERTAKER	ADDRESS
Samuel J. Hemsley	578 N. Biddle

mation should be carefully supplied. Any information that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Pennington Ave ST., 35 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Freedman

(a) RESIDENCE NO. 902 Pennington Ave ST., 35 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel D. Freedman

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ...min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jack Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jack Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Balto St

15 Filed NOV 20 1921 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1921, to ——, 19....., that I last saw h is alive on Nov 17, 1921, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diarrhea

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis

(Signed) Leon D. Hodges, M. D.

, 19 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Herring Run — DATE OF BURIAL 11/20 19 21

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

N. B. WHITE PAPER should be carefully supplied. AGE should be stated EXACTLY. THIS SPACE should be filled in with care. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

091 64 D 58728

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 15 WARD)

2-FULL NAME Mrs. Jennie Klagsman

(a) RESIDENCE NO. 162 Bentalou St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Klagsman

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...brs. or ....min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E. Baltimore St

15 Filed NOV 20 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/21 19

17 I HEREBY CERTIFY, That I attended deceased from 11/17/21 .19 . to 11/18/21 .19 .

that I last saw her alive on 11/18/21 .19 .

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

OTH

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Ginsburg M. D.

11/19 19 21 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mount Rood — DATE OF BURIAL 11/20 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may he stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral hemorrhage due to high blood pressure. Phy. states name is Hachmann

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58729

CERTIFICATE OF DEATH.

154 D 58729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 633 N. Bond St. (ST.) (WARD) 7

2-FULL NAME Rosa Pritzker

(a) RESIDENCE NO. 633 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dave Pritzker.

6 DATE OF BIRTH (month, day, and year) Thrus

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis (Address) 1411 E Balto St

15 Filed NOV 20 1921 19 ROBERT A KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1921, to Nov 19, 1921,

that I last saw h alive on Nov 19, 1921,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

old age

(duration) yrs. mos dys

CONTRIBUTORY (Secondary) Cardiac dilatation 3 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A J Isaacs M. D.

11/19 1921 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herrn Hebrew Rodef Sholom DATE OF BURIAL 11/20 1921

20 UNDERTAKER Jack Louis ADDRESS 1411 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, ground for CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 58730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111

D 58730

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sara Allison

(a) RESIDENCE NO. 2209 Brookfield Ave City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Theodore Allison

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Hinde Fashman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country) [redacted] Fashman

14 Informant Lena J. Allison
(Address) (Sister)

15 Filed NOV 20 1921 [redacted] Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1921.

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1921, to Nov. 19, 1921, that I last saw her alive on Nov. 19, 1921, and that death occurred, on the date stated above, at 1 00 p. m.

The CAUSE OF DEATH* was as follows:

Acute yellow atrophy of Liver.

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 2209 Brookfield ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. L. Duncan, M. D.

11/19, 1921 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Southern Ave

DATE OF BURIAL 11/20 1921

20 UNDERTAKER Jack Lewis

ADDRESS 1411 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Berman.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58731

53-097

D 58731

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., V WARD)

2-FULL NAME Mrs. Eva Berman

(a) RESIDENCE NO. 1808 E. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1411 E. Balto

15 FILED NOV 20 1921 ROBERT A. KRAUSE Registrar Board of Health Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19/21

17 I HEREBY CERTIFY, That I attended deceased from 8/2/21, 19 , to 11/19/21, 19 .
that I last saw h[illegible] alive on 11/19/21, 19 ,
and that death occurred, on the date stated above, at 9.30 P. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. 9 mos. 4 ds.
CONTRIBUTORY (Secondary) Hodgkin's Disease
(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Zinberg M. D.
11/19 19 21 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	11/20/21
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58732

CERTIFICATE OF DEATH.

D 58732
REGISTERED No. C

1-PLACE OF DEATH mt Winans

CITY OF BALTIMORE: (No. 8 Annapolis ave ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula C. Batze.

(Residence in Baltimore: No. 8 Annapolis ave mt Winans St.; ..... yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Infant

6-DATE OF BIRTH, June 11, 1921.
(Month) (Day) (Year)

7-AGE, mo yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Fred. Batze

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Lula East.

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Batze

(Address) mt Winans

15-

Filed ..... 191.. HOWARD A. KELLY
NOV 20 1921 Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11 1921, to Nov 19 1921, that I saw her alive on Nov 15 1921, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(Duration) mo yrs. 5 mos. 8 ds.

CONTRIBUTORY (Secondary) Meningitis

(Duration) mo yrs. mo mos. 14 ds.

(Signed) Raymond Gilliam, M. D.

Nov 12, 1921. (Address) Lochearn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Fowler Park	Nov. 21, 1921
20-UNDERTAKER	ADDRESS
George J Smith	1000 W Fayette st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58733

CERTIFICATE OF DEATH.

154 D 58733

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Club Rd Roland Park St.) 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah J. Valiant

(Residence in Baltimore: No. 210 Club Road Roland Park St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, Apr 4, 1826
(Month) (Day) (Year)

7-AGE 95 yrs. 7 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER. Joseph Walker

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Elsa Stacy

13-BIRTHPLACE OF MOTHER (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos G. Valiant

(Address) 210 Club Road Roland Park

15-

Filed ..... 191.... [illegible] Registrar.

NOV 2 01921

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1900 to 1921, to Nov 19 1921, that I saw h[illegible] alive on Nov 19 1921, and that death occurred, on the date stated above, at 3 10 P m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 95 yrs. 7 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John J. Kane M. D.

Nov 19 1921 (Address) 1425 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Nov 21, 1921

20-UNDERTAKER Ger J Smith — ADDRESS 1000 N. Fayette St

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58734

CERTIFICATE OF DEATH.

170 D 58734

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1919 W. Mulberry ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas L. Miller

(Residence in Baltimore: No. 1919 W. Mulberry St. St.; 1 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Oct (Month) 18 (Day), 1845 (Year)

7-AGE, 76 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Frederick Co Md

PARENTS.

10-NAME OF FATHER, George Miller

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER Mary Cranes

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... T. Irving Miller

(Address) 1919 W. Mulberry St

15- ROBERT J. KRAUSE

Filed ..... 191.....

NOV 20 1921 Burial Permit No. .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1921, to Nov. 19 1921, that I saw him alive on Nov. 18 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Interstitial Nephritis

..... (Duration) 3 yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Thomas L. Miller M. D.

Nov 19, 1921 (Address) 1227 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery Frederick Md

DATE OF BURIAL, Nov. 26, 1921

20-UNDERTAKER Geo. J. Smith

ADDRESS 1000 W. Fayette St

N.B. Every question must be answered, if the information cannot be obtained, write "Unknown." CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Byrd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58735

CERTIFICATE OF DEATH.

91 D 58735

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 430 N. Gilmor ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Byrd

(a) RESIDENCE. NO. 430 N. Gilmor ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer) Washing Ironing etc
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Essex Co. Va.

PARENTS

10 NAME OF FATHER George Washington Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Lucy Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co Va

14 Informant Lelia Mymore
(Address) 430 N. Gilmor

15 Filed NOV 20 1921, 19

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to Nov 17, 1921, that I last saw h.. alive on Nov 16, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Age - Environment

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 822 Woodyear St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Haughey, M. D.

18, 1921 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bowly Mt Essex Co Va	Nov 20 1921
20 UNDERTAKER Sam'l W Chase & Son	ADDRESS 1400 Mosher St

NOV 20 1921

---

mation should be carefully supplied. Age should be stated in last birthday. Exact statement of OCCUPA-
at it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it
CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58736

CERTIFICATE OF DEATH.

- 78 D 58736

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 721 Baker ST.: (15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Holmes Carter

(a) RESIDENCE. NO. 721 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Levi Carter

6 DATE OF BIRTH (month, day, and year): June 20. 1884

7 AGE — Years: 37 Months: 3 Days: 29

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer): Virginia Public Schools

(c) Name of employer: Essex Co. Va

9 BIRTHPLACE (city or town) (State or country): Essex Co. Va

PARENTS

10 NAME OF FATHER: Edwood Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co Va.

12 MAIDEN NAME OF MOTHER: Lucy Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co. Va

14 Informant: Pinkney Ward (Address) Tappahannock Va. Mount

15 Filed NOV 20 1921 19 ROBERT J. KRAUTER

Burial permit O[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1921, to Nov 19, 1921, that I last saw her alive on Nov. 18, 1921, and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows: 2.20 A.M.

Pulmonary Tuberculosis

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright M. D.

Nov 19 1921 (Address) 1209 Preston ave St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 21 1921
20 UNDERTAKER	ADDRESS
Jam[illegible] W. Chase How	1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Septimus P. Justin

D 58737 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 181 E. Lexington St. St.: 27 WARD) REGISTERED No. C 79

2-FULL NAME Septimus Paul Justin

(Residence in Baltimore: No. 114 Montebello Terrace St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Feb (Month) 14 (Day), 1847 (Year)

7-AGE: 74 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Surveyor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balt City

PARENTS.

10-NAME OF FATHER: Joseph Justin

11-BIRTHPLACE OF FATHER (State or Country): Balto. md

12-MAIDEN NAME OF MOTHER: Mary Wilson

13-BIRTHPLACE OF MOTHER (State or Country): Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret A Justin

(Address) 114 Montebello Terrace

15-FILED NOV 20 1921 SOLOMON I. STAUFER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) yrs. Don't know mos. ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. Don't know mos. ds.

(Signed) W. H. Forscal (Coroner) M. D.

Nov 19 21 (Address) 117 W Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Park Cemetery

DATE OF BURIAL: Nov 22nd 1921

20-UNDERTAKER: Geo. Schilling & Sons

ADDRESS: 1126 E Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58738

CERTIFICATE OF DEATH.

40 D 58738

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2921 W. North Av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Camilla H Windsor

(Residence in Baltimore: No. 2921 W. North Av St.; 20 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	widow

6-DATE OF BIRTH, Dec. 24, 1853
(Month) (Day) (Year)

7-AGE, 68 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Darden D. Hall

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER, Mary Boyer

13-BIRTHPLACE OF MOTHER (State or Country), Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. D. Hall

(Address) 431 Mununy Bldg.

15- Filed NOV 20 1921 [illegible] Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 1921, to Nov. 18 1921, that I saw her alive on Nov. 18 1921, and that death occurred, on the date stated above, at 12, noon m.

The CAUSE OF DEATH* was as follows:

Disease of Liver
(Probably Carcinoma)

(Duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

(Signed) H. C. Dodd M. D.

Nov 20, 1921 (Address) 3101 Clifton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Nov 21, 1921
20-UNDERTAKER Chas. E. Branch	ADDRESS 807 Madison Ave

N. B.—Every item of information should be given as correctly as possible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 58739

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Wilhelm ST. 70 WARD)

2-FULL NAME John Reinhart

(a) RESIDENCE: NO. 2006 Wilhelm ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year) 12 Dec 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hair Dyer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: The Kins Factory

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frank Reinhart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Elizabeth Handy
(Address) 2006 Wilhelm St.

15 Filed NOV 20 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1921, to Nov 18, 1921, that I last saw him alive on Nov 18, 1921, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma
Emphysema ?
× Arteriosclerosis (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) General Asthenia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Carcinoma, M. D.

Nov 19 (Address) - 3450 Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: NOV 21 1921

20 UNDERTAKER: MR. & MRS. N. S. FINK, FUNERAL DIRECTORS, 1835 W. PRATT STREET — ADDRESS

Burial Permit Issued

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1200 D 58740

CERTIFICATE OF DEATH.

D 58740

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3632 Hickory Ave. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Keys

(a) RESIDENCE. NO. 3632 Hickory Ave. ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if of foreign birth? 74 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Wm. H. Keys

6 DATE OF BIRTH (month, day, and year) Dec. 18-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas C. Keys (Address) 3632 Hickory Ave

15 Filed NOV 20 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1921, to Nov. 18, 1921.

That I last saw h. alive on Nov. 17, 1921.

and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
& Senility

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

1921 (Address) 846 W 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov. 21 1921
UNDERTAKER Horace H. Burgee	ADDRESS 3631 Falls Rd.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58741

CERTIFICATE OF DEATH.

79 D 58741

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 E Balto ST.: | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tillie Lerner

(a) RESIDENCE. No. 2203 E Balto ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Lubman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Malkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Lerner
(Address) 2203 E Balto st

15 NOV 20 1921 BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 20, 1921, that I last saw her alive on Nov 20, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M J Baylin, M. D.

11/20, 1921 (Address) 210 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale Cemetery	Nov 20 1921
20 UNDERTAKER Max Lerner	ADDRESS 1127 E Balto st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 58742 HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 58742

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 S. Payson ST., 20 WARD)

2-FULL NAME Abraham Scotland

(a) RESIDENCE NO. 433 S Payson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Yedel Statcand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ecodstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. Macopsky
(Address) 433 S. Payson

15 NOV 20 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 19, 1921.
that I last saw h in alive on Nov 19, 1921,
and that death occurred, on the date stated above, at 3 15 a m.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Ep Pneumonia.
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harry Goldberg M. D.
, 1921 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Pk	Nov 20 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to
chr. valvular lesion

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58743

CERTIFICATE OF DEATH.

53

D 58743

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lake Dennett St. 12 Ward)

2-FULL NAME Julius L. Krauss

(a) RESIDENCE. No. Lake Drive St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Krauss

6 DATE OF BIRTH (month, day, and year) July 8th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Leopold Krause

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elesa Hirsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs B Krauss
(Address) Lake Drive

15 NOV 20 1921 ROBERT J. KRAMER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6th, 1920, to November 19, 1921, that I last saw him alive on Nov 19, 1921, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Leukemic Lymph-Adenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood findings

(Signed) Millard A. Abrams, M. D.

, 19 (Address) 7360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chet Shalom	Nov 21st 1921

20 UNDERTAKER	ADDRESS
Hart Sondheim	1818 W. Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58744

D 58744

CERTIFICATE OF DEATH.

REGISTERED No. C 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Mc Culloh ST.; 64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgianna Freeman

(Residence in Baltimore: No. 1907 Mc Culloh St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fmal

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Jan 1st, 1871.
(Month) (Day) (Year)

7-AGE. 50 yrs. 8 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 637

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Allen

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Carter

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Freeman

(Address) 1907 Mc Culloh St

15-NOV 20 1921 ROBERT J KRAUTER

Filed ....., 191.... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18th, 1921.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Nov 18 1921, that I saw her alive on Nov 18 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Ex Uraemia

(Duration) yrs. 11 mos. ds.

(Signed) D D Hughes M. D.

Nov 19 21, 191.. (Address) 1413 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Nov 21 25, 1921.

20-UNDERTAKER Geo H Holland — ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

No other abnormal condition

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58745 (1922)

4V D 58745

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Walker

(a) RESIDENCE. No. 556 Robert St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Born, never ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Abram Walker

6 DATE OF BIRTH (month, day, and year): March 4th 1881

7 AGE: Years 40 Months 8 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Allison

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Emily Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed NOV 20 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1921, to Nov. 18th, 1921, that I last saw her alive on Nov 18th, 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of cervix

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 13, 21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Leo Brady, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Auburn Cem.	Nov. 22nd 1921
20 UNDERTAKER: Geo. H. Holland	ADDRESS 1031 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58746 — REGISTERED NO. D 58746

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1153 N Caroline St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Chavis

(a) RESIDENCE. NO. 1153 N Caroline St. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Chavis

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	X	X	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Operating Motor Co.
(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) (State or country) Not given Md

PARENTS

10 NAME OF FATHER Not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah Chavis (Address) 1153 N Caroline

15 NOV 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1921, to Nov 16, 1921, that I last saw h[illegible] alive on Nov 16, 1921, and that death occurred, on (the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Cardiac (mitral) insufficiency
Ventricular Paralysis.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) mitral insufficiency
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope

(Signed) Edw Short, M. D.

11/17, 1921 (Address) 1512 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov. 20 1921

20 UNDERTAKER Edward Ruggoff ADDRESS 1963 Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58747

CERTIFICATE OF DEATH.

80 D 58747

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2713 Penna Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph. M. Waissman

(Residence in Baltimore: No. 2713 Penna Ave St.; 3 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 11 (Day), 1882 (Year)

7-AGE, 38 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Store
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Russia

PARENTS:
10-NAME OF FATHER, Juda Waissman
11-BIRTHPLACE OF FATHER (State or Country) Russia
12-MAIDEN NAME OF MOTHER Untrown
13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Waissman

(Address) 2713 Penna Ave

15- NOV 20 1921 Filed ..., 191... ROBERT J. KRAUTH Registrar. Vital Statistics Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) I find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Kennedy M. D. (Coroner.)

Nov 20, 1921 (Address) 2802 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Wash. Road Hebrew DATE OF BURIAL, Nov. 20, 1921

20-UNDERTAKER S. Levenson ADDRESS 1127 Balto. St.

Should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA- on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

GV D 58748

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Wolfe

(a) RESIDENCE. No. 825 S. Bouldist. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 191 7.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Henry Wolfe

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Nettie Dannenfelser

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

rmant Nettie Wolfe

ss) 825 S. Bouldin St

NOV 20 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1921

17

I HEREBY CERTIFY, That I attended deceased from 11-5-21, 19, to 11-19-21, 19.

that I last saw h alive on 11-19-21, 19,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Empyema.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of 11-6-21

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) Frank C. Harris, M. D.

(Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Nov 22 1921
UNDERTAKER Zitzler & Zitzler	ADDRESS 1734 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George [illegible]. Dennis

(a) RESIDENCE. No. 925 China St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Dennis

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cecil Co., Maryland

PARENTS

10 NAME OF FATHER: Peter Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sommerset Co Maryland

12 MAIDEN NAME OF MOTHER: Emma Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sommerset Co. Maryland

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed . 19 [illegible] Registrar

NOV 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 17, 1921, to November 18, 1921, that I last saw him alive on November 18, 1921, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

(Address) Municipal Hospital. 11/18/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov 21 1921
20 UNDERTAKER	ADDRESS
J. C. Brown & Son	1631 W. Mulb

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 53750

58750 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Clarks Hill ST.; 27 WARD) Mt Washington

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Laura Randle

(Residence in Baltimore: No. above ST.; Towson yrs. 6 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Fem.

4-COLOR OR RACE White

5-~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) Married

6-DATE OF BIRTH Jan 28 (Month) (Day) 1878 (Year)

7-AGE 43 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md

PARENTS

10-NAME OF FATHER Robt. Fishpaw

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Sarah Jane Tews

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. S Dewey Wisler

(Address) Clarks Hill

15- Filed NOV 21 1921 BOARD OF HEALTH Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 11 (Month) 18 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May, 1921, to Date 11/1921, that I saw her alive on 11/17 1921, and that death occurred, on the date stated above, at 1.00 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yr. mos. ds.

Contributory (SECONDARY) Coma - Paralysis

(Duration) yrs mos ds.

(Signed) Henry F. Randle M. D.

11/19 1921 [Address] Roland Park

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Prospect Hill

DATE OF BURIAL Nov 21 1921

20-UNDERTAKER John Burns Sons

ADDRESS Towson

Spec.—8-24-14—M. & T.—2000 Bks.

D 58751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 58751

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Coleman

(Residence in Baltimore: No. 1021 N. Bruce St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1886 (Year)

7-AGE,	If LESS than 1 day,
35 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

PARENTS.

9-BIRTHPLACE, (State or Country): Balto City Md.

10-NAME OF FATHER: W. E. C. Ross

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Don't know

13-BIRTHPLACE OF MOTHER (State or Country): Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ellis Smith

(Address) 1211 N. Wilson al

15- NOV 21 1921 191... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 12 1921, to Nov. 19 1921, that I saw h[illegible] alive on Nov. 19 1921, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Louis M. Frank M. D.

Nov. 19, 1921. (Address) Frank. Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	NOV. 22, 1921.
20-UNDERTAKER	ADDRESS
Daniel Easton	916 Pine

N. B.—Every item of information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks .....

Luetic in origin

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58752 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58752

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Maryland Av St.) 12 105 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Estelle Worthington

(Residence in Baltimore: No. 1811 Maryland Av St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fmal.

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, June 4, 1918
(Month) (Day) (Year)

7-AGE, 3 yrs. 5 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER James Worthington

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ramsay V. Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Worthington

(Address) 1811 Maryland Ave

15- NOV 21 1921 [illegible] A. KRAUTER [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov — 18, 1921.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov 18 1921, to Nov 18 1921, that I saw h er alive on Nov 18 1921, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTING (Secondary) Exhaustion (Sepsis)

(Duration) ... yrs. ... mos. 1 ds.

(Signed) D. Hughes, M. D.

Nov 18, 1921 (Address) 1413 Druid Hill Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	Nov 20, 1921.
20-UNDERTAKER Daniel Easton	ADDRESS 916 E Av

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If LESS than 1 day, HOURS or MINUTES should be stated. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58753

91 D 58753

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1713 Lamont Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Joseph Hoffman

(a) RESIDENCE. NO. 1713 Lamont Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 1-18-21

7 AGE: Years — Months 10 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000 Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Theo. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Eliz. Butz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Elizabeth Hoffman 1713 Lamont Ave

15 [illegible] 19 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1921, to Nov 18th, 1921, that I last saw him alive on Nov 18th, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows: OVER

Broncho-Pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary): Asthma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs Symptoms

(Signed) L. M. C. Clarke, M. D.

Nov 19 1921 (Address) 1114 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 11/21/21

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary broncho pneumonia

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE (Karter) ✓

D 58754

CERTIFICATE OF DEATH.

50 D 58754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 S. Eden st ST., 3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Kaster

(a) RESIDENCE NO. 124 S Eden st ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Kaster

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	73	—	—	

8 OCCUPATION OF DECEASED 845

(a) Trade, profession or particular kind of work Common

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J Lewis 1411 E Balto st

15 Filed NOV 21 1921 ROBT. I. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1921, to Nov 20, 1921,

that I last saw him alive on Nov 15, 1921,

and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus 4 years or more in duration. Chronic nephritis. Arterio obliterans Gangrene (leg)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis & gangrene

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Frank G. Lewis, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale C

DATE OF BURIAL 11/21 1921

20 UNDERTAKER Jack Lewis 1411 E Balto st

ADDRESS

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58755 Monique

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D 58755

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 238 S Spring ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cephalus Monique

(Residence in Baltimore: No. 238 S Spring St St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	Negro	Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 2 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER Albert Monique

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Estie Carter

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Della Washington

(Address) 238 S Spring St

15- NOV 21 1921 Filed, 191. [illegible] Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia Pneumonia

to Lobular (Duration) yrs. mos. ds.

(Signed) Henry Taylor Smallwood M. D. (Coroner)

Nov 19, 1921 (Address) Medical Arts Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Centura Cemetery	Nov 21, 1921
20-UNDERTAKER James A. Deems	ADDRESS 302 Forrest Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58756

CERTIFICATE OF DEATH.

D 58756

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1510 Pratt man ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florine Kelson

(Residence in Baltimore: No. 1510 Pratt man St.: 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. October 9 1900
(Month) (Day) (Year)

7-AGE. 21 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer). Pvt

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER. Thos. T. Kelson

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Matilda Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. T. Kelson

(Address) 1510 Pratt man St.

15- NOV 21 1921 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sat. Nov 19th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4th 1921, to Nov 19th 1921, that I saw h[illegible] alive on Nov 18th 1921, and that death occurred, on the date stated above, at 7:55 a.m.

The CAUSE OF DEATH* was as follows:

Acute Phthisis

(Duration) 4 mos. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) Gradual yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 21st 1921 (Address) 607 N. Gaston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Nov 23, 1921

20-UNDERTAKER James H. Dennis

ADDRESS 1200 Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Hunt.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58757

D 58757

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer W. Hunt

(a) RESIDENCE. NO. 127 Overland Ave Mantebello Park. ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Showman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Side Show at Fairs

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Jamestown N.Y.

PARENTS

10 NAME OF FATHER Wm C Hunt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamestown N.Y.

12 MAIDEN NAME OF MOTHER Gertrude E Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamestown

14 Informant Elmer W Hunt.

(Address) 127 Oakland Ave

15 Filed NOV 21 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/21 19

17 I HEREBY CERTIFY, That I attended deceased from 10/21/21 19 to 11/18/21 19

that I last saw h[illegible] alive on 11/18/21 19

and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows: Acute Ryg[illegible] Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. A. Tompkins, M. D.

(Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL Nov 22 1921

20 UNDERTAKER [illegible] ADDRESS 2[illegible] Edmondson

N. B.—WRITE PLAINLY. All questions should be answered. PHYSICIANS should be careful to see that every statement is correct. Exact information should be carefully supplied. AGE should be stated in every case. OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58758

CERTIFICATE OF DEATH.

1340 D 58758

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene (St.:) 19 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Joyner

(a) RESIDENCE. No. 1636 Hollins St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) 13 Feb 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Joyner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter Joyner (Address) 1636 Hollands st

15 Filed NOV 21 1921 ROLLA P. CRAFT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 19, 1921, that I last saw h[illegible] alive on Nov 19, 1921, and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Surgical Shock. Ord.

(duration) yrs. mos. ds.

CONTRIBUTORY Pernicious Vomiting of Pregnancy

Post-mortem [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-18-21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Morris Slemons, M. D.

11-19-1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Cemetery	Nov 21 1921
20 UNDERTAKER	ADDRESS
Josiah Lyon	1600 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr Reese said by phone that the operation was merely a low forceps in a 30 wk pregnancy. The cause of death is Pregnancy — Pernicious vomiting, secondary

O.H.J

Mary E. Chase

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58759

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 109 D 58759

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Chase.

(a) RESIDENCE. NO. Emmitsburg Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Chase

6 DATE OF BIRTH (month, day, and year) Oct 25, 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware.

PARENTS

10 NAME OF FATHER Thomas Wright.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Sarah Arants.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. John T. Chase (Address) Emmitsburg Md

15 Filed NOV 21 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1921, to Nov 18, 1921, that I last saw h-r alive on Nov 18, 1921, and that death occurred, on the date stated above, at 7: m.

The CAUSE OF DEATH* was as follows:

Post Operative Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 17, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo L Wiseman, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Nov. 21 1921

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 58760

REGISTERED NO.

D 58760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 815 Pierce ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos Acton

(a) RESIDENCE. NO. 815 Pierce ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Acton

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. A. Co. md

9 BIRTHPLACE (city or town) (State or country) Unknown Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eliza Acton (Address) 815 Pierce St

15 Filed NOV 21 1921 ROBERT A. BRAUNE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 1921, to Nov 19, 1921.

that I last saw h alive on Nov 19, 1921.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Pulm Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date?

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

Nov 20 1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem DATE OF BURIAL Nov 22 1921

20 UNDERTAKER Chas. E. Alexander ADDRESS 721 Lanvale

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WHERE KNOWN, ANSWER EACH QUESTION. WHERE UNKNOWN, ASK—THIS IS A PERMANENT RECORD. AFFIDAVITS ARE ADDED WHEN NECESSARY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mamie Barrett

HEALTH DEPARTMENT—CITY OF BALTIMORE

28-091

D 58761

CERTIFICATE OF DEATH.

D 58761

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1249 Orleans St ST., 5 WARD)

2-FULL NAME Mamie Barrett

(a) RESIDENCE NO 1249 Orleans St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
18	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) born in Baltimore City

PARENTS

10 NAME OF FATHER Geo Oneal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Malindia Postell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Malindia Barrett (Address) 1249 Orleans av

15— NOV 21 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1921, to Nov. 19, 1921, that I last saw her alive on Nov. 19, 1921, and that death occurred, on the date stated above, at 9.35 A. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs
Broncho Pneumonia &
Tuberculosis of Lungs

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Tuberculosis of Lungs (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. G. McKennard M. D.

19. 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Nov 22 1921

20 UNDERTAKER Mrs Robert-A Elliott — ADDRESS 1721 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 17 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis H Richardson

(Residence in Baltimore: No. 631 N Paca St

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colord	Sigle

6-DATE OF BIRTH, Dont Know (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
46 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Gro

9-BIRTHPLACE, (State or Country), born in Balt

PARENTS.

10-NAME OF FATHER, Balto md, Lewis H Richardson

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Da

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A Richardson

(Address) 631 N Paca St

15-

Filed NOV 21 1921 191.. [redacted] Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, an~~ ~~autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) Dont Know ds.

CONTRIBUTORY (Secondary) Do not Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

11-20, 1921 (Address) 17 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Nov 23 1921

20-UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

B 58763 HEALTH DEPARTMENT—CITY OF BALTIMORE 61-001 D 58763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Bell

(a) RESIDENCE. NO. 1920 N. Chester St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18th 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ephraim Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Dobbiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 NOV 21 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1921, to 11-20, 1921, that I last saw h[illegible] alive on 11-20, 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of No

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture

(Signed) Horace D. Stewart, M. D.

11/24. 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Nov 22nd 1921

20 UNDERTAKER Bertram Lowe ADDRESS 1733 Eutaw Place

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All questions should be answered. AGE should be carefully supplied. PHYSICIANS should state mation should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 58764 HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 58764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Balto Gen. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light St. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Wallace

(a) RESIDENCE. NO. Brooklyn Md ST. Bapt Holy Cross & A & Co Cemetery WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17-1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor for 040

(b) General nature of industry, business, or establishment in which employed (or employer) Rivera Beach

(c) Name of employer Dearborn Co A A Co Md

9 BIRTHPLACE (city or town) (State or country) South River A A Co Md

PARENTS

10 NAME OF FATHER Loyed Wallace

11 BIRTHPLACE OF FATHER (city or town) South River (State or country) A A Co Md

12 MAIDEN NAME OF MOTHER Fannie A Robinson

13 BIRTHPLACE OF MOTHER (city or town) South River (State or country) A A Co Md

14 Informant Henry J Wallace (Address) Brooklyn A A Co Md

15 NOV 21 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 19, 1921, that I last saw him alive on Nov 19, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. H. Wilson M. D.

(Address) South Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	Nov 22 1921
20 UNDERTAKER	ADDRESS
John F Denny	715 L St

N. B.—WHITE PAPER. BLACK INK. TYPEWRITER. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58765

CERTIFICATE OF DEATH.

170 D 58765

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

▲ 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Russell ST., 21 WARD)

2-FULL NAME Wm J. Faulbank

(a) RESIDENCE NO. 906 Russell ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Faulbank

6 DATE OF BIRTH (month, day, and year): April 12-1830

7 AGE: Years 91 | Months 7 | Days 7 | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 061

(b) General nature of industry, business, or establishment in which employed (or employer): Police Officer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER Wm Faulbank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Elizabeth Merchant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Chas M Fortner Guilford Ave

15 Filed ..... 19 ..... Registrar

NOV 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 19 21, to Nov 19, 19 21, that I last saw h alive on Nov 19, 19 21, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion Chronic

(duration) 6 yrs. 4 mos 6 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Guerin, M. D.

Nov 20, 19 21 (Address) 517 Lenox St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvert Cemetery — DATE OF BURIAL: Nov 22 1921

20 UNDERTAKER: W A Whitehurst — ADDRESS: Balto Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

Bosson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58766

CERTIFICATE OF DEATH.

D 58766

1-PLACE OF DEATH 2833 Pennsylvania Ave, REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 13 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Bozeman

(Residence in Baltimore: No. 2833 Pennsylvania Ave St.; 61 yrs. 5 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) October (Day) 16, (Year) 1860

7-AGE, 61 yrs. 5 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Stevenson Company

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, George E Bozeman

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary A Morfoot.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. D. Shaffer

(Address) 3811 Wordsworth Ave

15- NOV 21 1927 ROBERT J KRAUTER Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 19, (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1920 to Nov 19 1927, that I saw h[illegible] alive on Nov 19 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was ~~as follows~~:

Chronic Interstitial Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) John Etzwiler M. D.

Nov 21 1927 (Address) 714 N Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, 11/21/27 191...

20-UNDERTAKER W J Treleven & Sons ADDRESS Penna & North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58767

CERTIFICATE OF DEATH.

28 D 58767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boyd Holloman

(a) RESIDENCE. No. 702 Redwood St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Holloman

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Preston Holloman

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Charlotte Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records (Address) M.T.H.

15 NOV 21 1921 ROBERT I. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1921, to Nov. 18, 1921, that I last saw him alive on Nov. 18, 1921, and that death occurred, on the date stated above, at 8.14 p. m.

The CAUSE OF DEATH* was as follows:

Pyopneumothorax (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in Sputum, X-ray

(Signed) Frances L Dudgeon M. D.

11-19-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 20 1921
20 UNDERTAKER	ADDRESS
R C Grock	1405 Mcelderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58768 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 58768

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 652 (St.) Eutaw Ave (Ward) 9

2-FULL NAME Elizabeth Jane Briddell

(a) RESIDENCE No. 652 St. Eutaw Ave Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuel R Stirling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Echerton

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mr Peregoy
(Address) 10 Hillen Pl Edmondson Road

15 Filed NOV 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1921, to Nov 20, 1921, that I last saw h[illegible] alive on Nov 9, 1921, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.
Cardiac valvular disease.

(duration) yrs. 4 mos. 2 ds.

CONTRIBUTORY (Secondary) Decompensated Cont.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) George A. Bunde, M. D.

, 19 (Address) 1512 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park C	Nov 23rd 1921

20 UNDERTAKER: Geo. W. Rice & Son — ADDRESS: 2503 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58769

CERTIFICATE OF DEATH.

D 58769

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1010 N Eden ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L Wolf

(a) RESIDENCE. NO. 1010 N Eden ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Wolf

6 DATE OF BIRTH (month, day, and year) Nov 7 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk (Clerk)

(b) General nature of Industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Wolfe (Address) 1010 N Eden

15 Filed NOV 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1921, to Nov 18th 1921, that I last saw h.e alive on Nov 14 1921, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fenwick L Emmons, M. D.

Nov 21, 1921 (Address) 1400 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 22 1921
20 UNDERTAKER	ADDRESS
Windell Oppel & Son	378 Am

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58770

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 S. Fourth. ST.: 76 WARD)

2-FULL NAME. Mary A. Beler.

(a) RESIDENCE. NO. 803 S. Fourth. ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Conrad Beler.

6 DATE OF BIRTH (month, day, and year) May. 8th 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER ~~Unknown~~ Speterlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Elizabeth Beler.
(Address) 803 S. Fourth St.

15 NOV 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1921, to Nov 18, 1921, that I last saw her alive on Nov 18, 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. J. McAvoy, M. D.

11/21, 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov. 1921
20 UNDERTAKER Lilly & Jones	ADDRESS 1023 N. Mo[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-078 D 58771

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S. Fourteenth ST.: 26 WARD)

2-FULL NAME Thelma Merritt

(a) RESIDENCE. No. 312 S. Fourteenth ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Russell E. Merritt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie M. Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Russell E. Merritt. (Address) 312 S. Fourteenth St.

15 Filed Nov 19 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 19, 1921, that I last saw her alive on Nov 19, 1921, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchio - pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxemia of Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 312 S Fourteenth St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Charles L. Crook, M. D.

Nov 19 1921 (Address) 503 S. Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Nov 22 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V21 1921 Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58772

D 58772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 E. Lombard ST.: W WARD)

2-FULL NAME Susanna Schmidt.

(a) RESIDENCE. NO. 1919 E. Lombard ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John A. Schmidt

6 DATE OF BIRTH (month, day, and year) Aug 1st 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Kuhn.
(Address)

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18th 1921

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to Nov. 18, 1921, that I last saw her alive on Nov. 18, 1921, and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 8 mos. 18 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Cronin, M. D.

Nov. 21, 1921 (Address) Ten Hills-Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 22 1921

20 UNDERTAKER Lilly + Zeiler ADDRESS 1033 S. Wolfe St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58773

CERTIFICATE OF DEATH.

D 58773

170 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2423 Guilford Ave 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Shaw

(a) RESIDENCE. NO. 2423 Guilford Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas G. Shaw

6 DATE OF BIRTH (month, day, and year): Dec 21 1862

7 AGE: Years 59 Months 11 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: William Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Katherine Boughter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Thomas G. Shaw 2423 Guilford Ave

15 Filed Nov 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

Settle 2435 Mt Ver.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921 to Nov 20, 1921, that I last saw her alive on Nov 20, 1921, and that death occurred, on the date stated above, at 9.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Mitral regurgitation

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical tests

(Signed) Fenn M. D. M. D.

11/21 19 (Address) 1435 Mary land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine cem. DATE OF BURIAL: Nov 22 19 21

20 UNDERTAKER: William Cook ADDRESS 602 E Balto

PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58774

CERTIFICATE OF DEATH.

D 58774

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1948 Ridgewood Ave ST.; 15 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E Cody

(Residence in Baltimore: No. 1948 Ridgewood Ave St.; 25 yrs. ..... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 23 (Day), 1856 (Year)

7-AGE, 65 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Boston Rommal

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lent Knox

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E Knowles

(Address) 1948 Ridgewood Ave

15- Robert P. Harrison,

Filed ....., 191.....

NOV 21 1921 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1921, to Nov 20 1921, that I saw her alive on Nov 20 1921, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Fred C. Jewett ..... M. D.

Nov 20, 1921 (Address) ..... 2516 Penn Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Nov 23, 1921

20-UNDERTAKER Mullican Cook — ADDRESS 507 E. North

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 137 D 58775

1-PLACE OF DEATH Union Memorial Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 14 ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Arthur Isaacsburger (Jessie)

(a) RESIDENCE. No. 4. Meadowbrook Road ST., WARD.
(Usual place of abode) Catonsville Md.

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. life ds. (If nonresident give city or town and State) Catonsville, Md.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White American

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Isaacsburger.

6 DATE OF BIRTH (month, day, and year): Jan. 8 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Thomas Simons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Katherine Dimmler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Hospital Rec (Address)

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1921, to Nov 19, 1921, that I last saw h[illegible] alive on Nov 19, 1921, and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

Abortion, with retained membranes
Puerperal infection.
Generalized Septicemia & pyemia.
(duration) — yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary): Septicemia (over)
(duration) — yrs. — mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 4 1921

Was there an autopsy? yes.

What test confirmed diagnosis? Blood culture.

(Signed) George E. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov. 23 1921

20 UNDERTAKER: Easton Sons — ADDRESS: Elkton City

NOV 21 1921

THIS IS A LEGAL DOCUMENT, WITH PENALTIES ATTACHED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

wall

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58776

CERTIFICATE OF DEATH.

79 D 58776

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 N. Lombard ST., 18 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt E B. Burns

(a) RESIDENCE NO. 900 N. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced (or) WIFE of Georgiana Burns

6 DATE OF BIRTH (month, day, and year) Nov 9/43

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist & blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) retired. 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Robert Burns
(Address) 1114 W Camden St

15 Filed NOV 22 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1921, to Nov 20, 1921, that I last saw him alive on Nov 18, 1921 and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency
Cardiac hypertrophy
Pulmonary oedema

about 2 3 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. E. Krantz, M. D.

(Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Nov 22 1921
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St

Spec.—19-1921—[illegible]—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1918 D 58777

14 D 58777

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St.: 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Kelly

(a) RESIDENCE. No. 217 N. High St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 22 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herbert Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Amy Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4th, 1921, to Nov. 20th, 1921, that I last saw him alive on Nov 20th, 1921, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Dysentery.

1

over

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Dysentery

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriology

(Signed) Horace G. Stewart, M. D.

11/20, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 23 1921
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Av.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Flexner's dysentery.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58778
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

64 D 58778
REGISTERED NO.

CITY OF BALTIMORE: (No. 2941-St-Paul-Street ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Tyson Procter

(a) RESIDENCE. No. 2941-St-Paul-Street ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? 59 yrs. 2 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Sep-5-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER Samuel T. Procter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Ellen H. Cowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Miss Nellie H. Procter (sister)
(Address) #2941-St-Paul-Street.

15 NOV 22 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-20- 1921.

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1921, to Nov 20 1921, that I last saw h[illegible] alive on Nov 20, 1921, and that death occurred, on the date stated above, at 9 15 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage causing Hemiplegia & Coma

(duration) — yrs. — mos. 1/2 ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferies Buck M.D.

11/22 1921 (Address) 2944 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery.	Nov-22- 21
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58779

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 17 Jew Hospital St.; 17 WARD)

Registered No. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geny C Elliott.

(Residence in Baltimore: No. 49 Bucknell a St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH, Mar 8th (Month) (Day), 1915 (Year)

7-AGE 6 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Walter J Elliott

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Martha Jacobi

13-BIRTHPLACE OF MOTHER (State or Country) Rochester N Y

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Elliott

(Address) 49 Bucknell Ave

15- NOV 22 1921 191.... BUREAU OF VITAL STATISTICS Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound. Fired
Pistol Accidentally self

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E J O'Malley M. D.
(Coroner.)

11-21, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood

DATE OF BURIAL, Nov 23, 1921

20-UNDERTAKER Robt J Turner Inc

ADDRESS 1442 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58780 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58780

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — N. Pimlico Rd.

REGISTERED NO.....

CITY OF BALTIMORE: (No. Greenspring Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Joseph A. Bauer

(a) RESIDENCE. NO. Greenspring Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Widowed

5a If married, widowed, or divorced
~~WIFE of~~ HUSBAND of Mary Bauer

6 DATE OF BIRTH (month, day, and year) 5/27/1834

7 AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
~~87~~ 87	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — Retired Dr
(b) General nature of industry, business, or establishment in which employed (or employer) — farmer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) — Maryland

PARENTS

10 NAME OF FATHER — Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Unknown

12 MAIDEN NAME OF MOTHER — Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Unknown

14 Informant — Mary Lockwood
(Address) — Green Spring Ave & Pimlico Road

15 Filed NOV 22 1921 — [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1. 1921. to Nov 21. 1921.
that I last saw h alive on Nov 21. 1921.
and that death occurred, on the date stated above, at 1 A m.
The CAUSE OF DEATH* was as follows:

Broncho x Hypostatic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial nephritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Cemetery Govan	Nov 23 '21
20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Harford ave

...B... matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

58781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69 D 58781

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Keyser ST.: 8 — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Howard

(a) RESIDENCE. No. 1614 Keyser ST., 8 — WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 25-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ernest E. Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sarah Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Ernest E. Howard
(Address) 1614 Keyser st.

15 Filed NOV 22 1921, 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20-1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 12, 1921, to Nov. 20, 1921, that I last saw him alive on Nov. 20, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy - Grand Mal

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby M. D.

11/29/1921 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 11/22/21 19

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58782 (X 54)

D 58782

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W. Rudd

(a) RESIDENCE. NO. Bronson Michigan ST., WARD.
(Usual place of nbode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia

6 DATE OF BIRTH (month, day, and year) 3-19-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Pants

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Lawrence Rudd

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Mary Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa.

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed NOV 22 1921 ESTHER I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-9, 1921, to 11-21, 1921, that I last saw h live alive on 11-21, 1921, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

PERNIC. ANEMIA

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for ndditional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bronson Michigan	Nov. 22 1921

20 UNDERTAKER ADDRESS

Wm. C. Black 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr Ball Pulledge 19 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

40-09D 58783

D 58783

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1132 E. North Av ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bittel

(a) RESIDENCE. No. 1132 E. North Av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bittel

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city ~~county~~) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Casper Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pinkerton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Polley

(Address) 1132 E North Ave

15 NOV 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/20 . 1921. to Nov 20 . 1921.

that I last saw h e alive on 11/20 . 1921.

and that death occurred, on the date stated above, at 630P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia 7 5 hours

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. 10 d.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Typical

(Signed) H H Shubert, M. D.

11/22 1921 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 23 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1527 N Charles St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

114

D 58784

CERTIFICATE OF DEATH.

D 58784

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 70 WARD)

2-FULL NAME James C. Conley.

(a) RESIDENCE NO. 3117 Wilkins Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs. Mary E. Conley

6 DATE OF BIRTH (month, day, and year) July 4 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phil. Pa.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs Mary Conley

(Address) 3117 Wilkins Ave

15 BOIST & KRAUTER

NOV 22 1921 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-20, 1921, to 11-21, 1921, that I last saw ~~him~~ her alive on 11-21, 1921, and that death occurred, on the date stated above, at 5-15 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis following Removal of stone in Common duct and Empyema of gall bladder

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home address

Did an operation precede death? Yes Date of 10-31-21

Was there an autopsy? Yes

What ~~test~~ confirmed diagnosis? autopsy

(Signed) H. W. Harper, M. D.

, 19 (Address) St. Agnes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
At Pikesville	Nov 24 1921
20 UNDERTAKER	ADDRESS
John L. Fields	1200 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58785

HEALTH DEPARTMENT—CITY OF BALTIMORE

156 D 58785

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 711 Warner St - St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Daily

(Residence in Baltimore: No. 711 S. Warner St - St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, ... Dont Know, 1 ..... (Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stevedor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 074

9-BIRTHPLACE, (State or Country), Jamaca W. Indias

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cephas Ball

(Address) 111 Russell St

15- FILED NOV 22 1921 19.. ROBERT J KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov - 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... ~~Jurors~~ ~~coroner~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction Fecal

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Gorsuch M. D. (Coroner.)

11-22, 1921 (Address) 117 N. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Albion — DATE OF BURIAL, Nov 22, 1921

20-UNDERTAKER R. L. Parlan — ADDRESS 649 N. Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58786

CERTIFICATE OF DEATH.

19 D 58786

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1612 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Maria Jennings

(a) RESIDENCE. No. 1612 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Jennings

6 DATE OF BIRTH (month, day, and year) [illegible] 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	[illegible]			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 007

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Albert C. Jennings
(Address) 1612 Baker St

NOV 22 1921

[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1921, to Nov. 20, 1921, that I last saw h[illegible] alive on " " 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) John D. Quinn, M. D.

11/21, 1921 (Address) 1507 N. Dulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters	Nov 25 1921

20 UNDERTAKER W. Cook ADDRESS 902 E. Oath

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 58787

D 58787

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Willow Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Beza. Nolan

(a) RESIDENCE. NO. 508 Willow Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) ~~HUSBAND~~ WIFE of Mr. Edward Nolan

6 DATE OF BIRTH (month, day, and year) Sept 19- 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1 mon		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward John Coyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Beza Coyne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Daughter) Teresa Nolan (Address) 508 Willow ave

15 Filed NOV 22 1921 19 ROBERT J. BRUTZE Registrar Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1921, to Nov 21, 1921, that I last saw h[illegible] alive on Nov 21, 1921, and that death occurred, on the date stated above, at 5 41 P. m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

protol (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

3 (duration) yrs. mos. whs.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) H. W. Wheaton, M. D.

, 19 (Address) 4235 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct. 24 1921

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

79

D 58788

CERTIFICATE OF DEATH.

D 58788

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 64 Market Space ST., 4 WARD)

2-FULL NAME Annie Kaminitz

(a) RESIDENCE NO. 64 Market Space ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 17 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Kaminitz

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E. Baltimore St.

15 Filed NOV 22 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/21 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1921, to Nov 21, 1921, that I last saw her alive on Nov 21, 1921, and that death occurred, on the date stated above, at 12 4 m.

The CAUSE OF DEATH* was as follows:

Cardiac + Resp. paralysis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chr. Valv. disease

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr D. Wallgate M. D.

, 19 (Address) 6 S. Exeter St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Northern Ave	11-22-1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58789

CERTIFICATE OF DEATH.

X 175-903

D 58789

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. South Baltimore General Hospital WARD) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Retz.

(Residence in Baltimore: No. English Consul Balto. Co. Md. 19 -------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, May 4th. 1887. (Month), / (Day), ... (Year)

7-AGE, 44 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Car repairer
(b) General nature of industry, business, or establishment in which employed (or employer)..... B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, William Retz.

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Elizabeth Williams.

13-BIRTHPLACE OF MOTHER (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Rose Retz. (wife)

(Address)..... English Consul Balto. Co.

15-

Filed..... NOV 22 1921, 191.....

Fellows Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 19th. 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Abdominal Injuries.
Accidentally crushed between cars
of B. & O. R. R. Co.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.
(Coroner.)

Nov. 20, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
B. & O. R. R. Yards Locust Point

Former or usual residence..... Nov 19th. 1921.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Nov. 22, 1921
20-UNDERTAKER	ADDRESS
Margaret O'Flynn	Arlington

Fabian Koczorowski ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

64D 58790

64D 58790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 717 S 13th St. V WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fabian Koczorowski

(Residence in Baltimore: No. 717 S 13th St

St.; yrs., 74 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widowed

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. 82 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE. (State or Country) Poland

PARENTS.

10-NAME OF FATHER. Stanislaus Koczorowski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Josephine .....

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Antonia Kowalewski

(Address) 1607 Lawrence St

15- .....

Filed ..... 191 .....
NOV 23 1921
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 20 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Apoplexy .....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... Henry Tyau ..... M. D.
(Coroner.)

Nov 20, 1921. (Address) 1806 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov. 23, 1921

20-UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58791

CERTIFICATE OF DEATH.

-152 D 58791

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 316 East ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Le Volsi

(a) RESIDENCE. NO. 316 East ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 21/21

7 AGE	Years	Months	Days	If LESS than 1 day 8½ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore city
(State or country)

PARENTS

10 NAME OF FATHER Pietro Le Volsi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Romano

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Josephine Romano
(Address) 316 East

15 Filed ..... 19 ROBERT J. BRAUTIGAM Registrar
NOV 22 1921 Social Form 1 Gloss

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to Nov 21, 1921, that I last saw her alive on Nov 21, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Birth Delivery

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emily L Dunkeath M. D.

Nov 22 1921 (Address) 1054 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	Nov. 22 1921
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 58792

HEALTH DEPARTMENT—CITY OF BALTIMORE

91

D 58792

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2100 E Balt Street

CITY OF BALTIMORE: (No.) Hebrew Chronic Home (ST.,) 5 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jachee Fell

(a) RESIDENCE (Usual place of abode) No. 262 N Exeter Street ST., WARD

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Fell

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Balto St

15 Filed NOV 22 1921 [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/21 19 21

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 20, 19 21, to Nov 21, 19 21,

that I last saw h[illegible] alive on Nov 21 19 21,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia. Bronchi.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wechsler M. D.

, 19 (Address) 1392 W Lombard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Sinai Cemetery	11-23 19 21
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137 D 58793

REGISTERED NO.

D 58793

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

NO. 726 S. Stricker ST.: 19 WARD)

2-FULL NAME Myrtle Estell Myers

(a) RESIDENCE. NO. 726 S Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Le Roy Myers

6 DATE OF BIRTH (month, day, and year) Aug 20 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James M Cheney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Poff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Le Roy Myers (Address) 726 S Stricker

15 NOV 22 1921 [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19 1921, to Nov 20 1921, that I last saw h. alive on Nov. 20 1921, and that death occurred, on the date stated above, at 6. P. M.

The CAUSE OF DEATH* was as follows:

Physical Exhaustion from Puerperia Psychosis of Several Months Standing

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Puerperal Infection

(duration) yrs. 6 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Cheney B. Hill, M. D.

, 19 (Address) Wyliam and City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 23 19 21

20 UNDERTAKER John Herring & Co

ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be properly classified. CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Schrl ✓

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58794

HEALTH DEPARTMENT—CITY OF BALTIMORE D 58794

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No.) ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Schrl

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 887

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hospital (Address) Balto, Md.

15 Filed NOV 22 1921 19 BURKE & KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1921, to Nov. 20, 1921, that I last saw him alive on Nov. 19, 1921, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) N. H. Edwards M. D.

11/20/21 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulaney	11/22/21

20 UNDERTAKER Dulaney Funeral ADDRESS 1316 Eutaw St

N. B.—WRITE PLAINLY. ALL QUESTIONS MUST BE ANSWERED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Wm H Grogan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58795

CERTIFICATE OF DEATH.

40

D 58795

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 709 E. Biddle ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Grogan.

(a) RESIDENCE. NO. 709 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Thos. Grogan.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Judy Eason.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot

14 Informant: Brother Thomas Grogan

(Address) 709 E Biddle St

15 Filed NOV 22 1921 [illegible] Registrar

[illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1924, to Nov 21, 1924, that I last saw him alive on Nov 21, 1924, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma? Cardiac

End of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) General weakness from

Lack nourishment (duration) yrs. mos. 15 ds.

18 Where was disease contracted, if not at place of death? 709 E Biddle

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Jerry M Pendleton, M. D.

Nov 23, 1921 (Address) 709 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/23/21

20 UNDERTAKER ADDRESS

H C Rudolph 914 Gwynns

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58796

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 58796

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2935 W. Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes. Letmate.

(a) RESIDENCE. NO. 2935 W Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of William J. Letmate

6 DATE OF BIRTH (month, day, and year) May 6 1893

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Michael Mannioni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Farrel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Wm. J. Letmate 2935 W. Mosher

Filed NOV 22 1921 ROLLIN E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921 to Nov 20, 1921.

that I last saw her alive on Nov 19, 1921;

and that death occurred, on the date stated above, at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. McCarty, M. D.

, 19 (Address) 87 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	11-23 1921

20 UNDERTAKER Mrs Chas A. G. Rohde ADDRESS 400 Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58797 ✓ D 58797.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58797 X 120

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Mt Hope Retreat

CITY OF BALTIMORE: (No. Baltimore ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Cassidy

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD. (Camden N.J.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr John P. Cassidy

6 DATE OF BIRTH (month, day, and year) Aug 18th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Delaware City (State or country) Del

PARENTS

10 NAME OF FATHER Henry Collins

11 BIRTHPLACE OF FATHER (city or town) Co Louth (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Courtney

13 BIRTHPLACE OF MOTHER (city or town) Longford Co (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Balto Md.

15 Filed NOV 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to Nov 21, 1921, that I last saw her alive on Nov 21, 1921, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH was as follows:

Nephritis Complicated by Uraemia Cum Convulsions

(duration) yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) Paramenbia Dysmosia

(duration) 0 yrs. 4 mos. 0 ds.

18 Where was disease contracted if not at place of death? New Jersey - Camden

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden - N.J. DATE OF BURIAL Nov 24 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58798

D 58798

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shelby.

(a) RESIDENCE. NO. 8 Beech St. Centre Bay, St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				4 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Shelby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co. Md

12 MAIDEN NAME OF MOTHER Anna Palerowzz

13 BIRTHPLACE OF MOTHER (city or town) Centre Bay (State or country) Maryland

14 Informant Charles Shelby (Father)
(Address) 8 Beech St Centre Bay.

15 Filed Robert P. Harrison, Registrar

NOV 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1921, to Nov 17, 1921, that I last saw h. l. alive on Nov 17 1921, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Premature.
(30 wks foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Eclampsia?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

11-18. 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS

NOV 9 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 58799

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 N Bond ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Francis Kearney

(a) RESIDENCE. No. 1502 N Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marella Kearney

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	1857	Nov	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Philip Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Rosa M. Leahy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wife Marella Kearney
(Address) 1502 N Bond St

15 Filed Robert P. Harrison, Registrar

NOV 22 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1921, to Nov. 20, 1921, that I last saw him alive on Nov 20, 1921, and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John D. Avery, M. D.

19 (Address) 1603 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov 23 1921
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Hanford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53800

CERTIFICATE OF DEATH.

1712

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1713 Madison ave ST.: 15 WARD) REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Foster J. Singer

(Residence in Baltimore: No. 2110 Herbert St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov. 20, 1868 (Month) (Day) (Year)

7-AGE, 53 yrs. mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050

9-BIRTHPLACE, (State or Country), Md,

PARENTS.

10-NAME OF FATHER, Wm. J. Singer

11-BIRTHPLACE OF FATHER (State or Country), Md,

12-MAIDEN NAME OF MOTHER Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), Md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella A. Singer

(Address) 2110 Herbert St.

15- Robert P. Harrison, 191 Registrar.

NOV 22 1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accident) above 5 minutes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fell down 3 st. staircase

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Nov. 22 1921 (Address) 202 Effingham Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Nov. 23 1921

20-UNDERTAKER Harry W. Ehlen ADDRESS 1944 W. Baltimore

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58801

CERTIFICATE OF DEATH.

78 D 58801

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Bradley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Lewis

(Residence in Baltimore: No. 628 Bradley St. 36 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Not Known ....., 1877
(Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... any Kind

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, not Known

11-BIRTHPLACE OF FATHER (State or Country), not Known

12-MAIDEN NAME OF MOTHER not Known

13-BIRTHPLACE OF MOTHER (State or Country), not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lewis

(Address) 628 Bradley St.

15-

Filed NOV 23 1921 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1921, to Nov 20 1921, that I saw h[illegible] alive on Nov 20 1921, and that death occurred, on the date stated above, at 2 10 m.

The CAUSE OF DEATH* was as follows:

Acute Endo-Carditis

(Duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) 0 yrs. 2 mos. 0 ds.

(Signed) R B Kenyon M. D.

Nov 21, 1921 (Address) 628 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Nov 23, 1921

20-UNDERTAKER Saml F Hensley

ADDRESS 575 N Bridle

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Not tuberculosis.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscafriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-19—H. P. Co.—1000 Bks.

D 58802

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St.: 4 Ward) REGISTERED No. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Blake

(a) RESIDENCE. No. 654 Josephine St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 30 years ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hessie Blake

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boot Black

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John R Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Dampeon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 23 1921 19 [illegible] Registrar

Serial No. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20th, 19 21, to Nov. 22, 19 21, that I last saw him alive on Nov. 22, 19 21, and that death occurred, on the date stated above, at 6 35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Uremia

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Cowles Andrus, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 24 1921
20 UNDERTAKER Saml T Hensley	ADDRESS 578 N Bdle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58803

CERTIFICATE OF DEATH.

1778 58803

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 W. 27th ST.: 12 WARD)

2-FULL NAME Norman F. St. John Jr.

(a) RESIDENCE. No. 307 W. 27th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19-19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Norman F. St John Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Elizabeth Dressel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Norman F. St John Jr.
(Address) 307 W. 27th St

15 Filed NOV 23 1921 ROBERT J. BRAUTE Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1921, to Nov. 21, 1921, that I last saw him alive on Nov. 20 1921, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Meningitis
Coroner's Inquest

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Fall from own porch about 3 mos ago

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? No, clinical

What test confirmed diagnosis?

(Signed) E B Bruton M. D.

Nov 21 1921 (Address) 1711 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL Nov 23 1921

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

N.B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58804

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hayes Harrison

(a) RESIDENCE. NO. 113 E. York St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed NOV 23 1921 ROBERT J. BRAMBLE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1921, to November 21, 1921 that I last saw him alive on November 20, 1921, and that death occurred, on the date stated above, at 5:35 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis; Aortic insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

11/21/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov. 23 1921
20 UNDERTAKER	ADDRESS
L L Brown & Son	108 N. Monty

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58805

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. North & Kelly aves. ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John N. Jones

(a) RESIDENCE. No. North & Kelly aves. Mt. Hasty. ST., 27 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3. yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Jennie Jones

6 DATE OF BIRTH (month, day, and year): Aug 27 1856

7 AGE — Years: 65 Months: 2 Days: 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired 030

(b) General nature of industry, business, or establishment in which employed (or employer): Locomotive Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Nicholas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Leas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Elmer N. Jones

(Address): 2711 W. Calvert St

15 Filed NOV 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1921

17 I HEREBY CERTIFY, That I attended deceased from August 1921, to Nov 22 1921, that I last saw him alive on November 21 1921, and that death occurred, on the date stated above, at 5.25 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) William J. Fida, M. D.

19 (Address) Mt Washington Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral DATE OF BURIAL: Nov 25 1921

20 UNDERTAKER: John A. Mitchell ADDRESS: 1201 W. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58806

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Nursery & Childs Hosp 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Nichles

(a) RESIDENCE. NO. N. & C. Hosp. ST.. ..... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 29th '21.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work —

(b) General natore of indostry, business, or establishment in which employed (or employer) — 800

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.. Md

PARENTS

10 NAME OF FATHER Peter Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece -

12 MAIDEN NAME OF MOTHER Francis Pagadolas -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece -

14 Informant C H Keehne
(Address) 1000 E. Fayette st

15 NOV 23 1921 [illegible] Registrar

Burial permit Oked

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22nd 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1921, to Nov. 22nd 1921,

that I last saw her alive on Nov 22nd 1921,

and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Nutritional Intoxication

(duration) yrs. 1 mos. 19 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Israel J Kringlen, M. D.

, 19 (Address) 1000 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 23 1921
20 UNDERTAKER	ADDRESS
Geo J Smith	1000 E Fayette st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

58807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 58807

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1821 W. Balto. St.; 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene I. Counselman.

(Residence in Baltimore: No. 1821 W. Balto. St.; yrs. 25 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Sept 3, 1889 (Month) (Day) (Year)

7-AGE: 32 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country.): Baltimore

PARENTS.

10-NAME OF FATHER: William L Childs

11-BIRTHPLACE OF FATHER (State or Country): Capon Co Md

12-MAIDEN NAME OF MOTHER: Annie L. Shackelford

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) William L Childs

(Address) 2023 Wilkens ave

15-

Filed NOV 23 1921 BOYD I KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound, (1 bullet) (Homicide)

(Duration) yrs. Instant mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) J. C. Wade M. D. (Coroner.)

Nov 23 1921. (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 24 1921

20-UNDERTAKER George J Smith — ADDRESS 1000 N. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58808

CERTIFICATE OF DEATH.

159 D 58808
REGISTERED No. C

1. PLACE OF DEATH
CITY OF BALTIMORE (No.) 1821 W. Balto. St. 19 WARD)
2. FULL NAME Howard H. Counselman
(Residence in Baltimore: No. 1821 W. Balto St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.
4-COLOR OR RACE: W.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Married
6-DATE OF BIRTH: Apr 16, 1886 (Month) (Day) (Year)
7-AGE: 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work: Salesman (b) General nature of industry, business, or establishment in which employed (or employer): O.R.
9-BIRTHPLACE (State or Country): Baltimore

PARENTS:
10-NAME OF FATHER: Augustus A. Counselman
11-BIRTHPLACE OF FATHER (State or Country): Baltimore
12-MAIDEN NAME OF MOTHER: Blanch Bell
13-BIRTHPLACE OF MOTHER (State or Country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William L. Childs
(Address) 2023 Hilkins Ave

15-
Filed NOV 23 1921
[illegible] B KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov 21 (Month) (Day), 1921 (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Two death on the day stated above.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound. (Suicide) (Homicide)
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock (Duration) yrs. mos. ds.
(Signed) J. C. Gladden M. D.
Nov 24 1921 (Address) 1436 N. Bway (Coroner)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 24 1921
20-UNDERTAKER: George J Smith — ADDRESS: 1000 W Fayette St

found from 32° Distol
& committed suicide after killing wife
with knives.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58809 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58809

CERTIFICATE OF DEATH

1-PLACE OF DEATH Robert Garrett Hospital for Children REGISTERED NO. 104

CITY OF BALTIMORE: (No. 27 N Carey ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Hood

(a) RESIDENCE. No. 1900 W. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 25th 1920

7 AGE — Years: 1 — Months: 2 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED — 000

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Cecil E. Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Rosa M. Auer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Mrs. Cecil E. Hood 1900 W. Lexington St.

15 NOV 23 1921 ROBERT P. STAUCK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1921, to Nov 22nd, 1921, that I last saw her alive on Nov 22nd, 1921, and that death occurred, on the date stated above, at 9 10 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) about yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. Clift, M. D.

11/22 1921 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Nov 23rd 1921

20 UNDERTAKER: Rose & B. Cook — ADDRESS: 1003 W. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58810

D 58810

Spencer-Walsh Print. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Hanover ST.: 23 WARD)

2-FULL NAME Mrs. Alice Thompson

(a) RESIDENCE. No. 1300 Hanover ST., 23rd WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John William Thompson

6 DATE OF BIRTH (month, day, and year) June 29, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) — — — —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. Balto.

PARENTS

10 NAME OF FATHER Benjamin Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John T. Thompson (Address) 1300 Hanover

15 Filed NOV 23 1921 19 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10th 1920 to November 21st 1921, that I last saw her alive on November 21st 1921, and that death occurred, on the date stated above, at 3 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) 1 yrs. 4 mos. 11 ds.

CONTRIBUTORY (Secondary) ..... (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings & sputum examination

(Signed) Harry Weibel M. D.

11/22 1921 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemetery	Nov. 23 1921
20 UNDERTAKER	ADDRESS
F. A. Trance & Son	703 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58811

D 58811

CERTIFICATE OF DEATH.

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1943 Patterson Place WARD) 8

2-FULL NAME William Kennewig

(a) RESIDENCE No. 1943 Patterson Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced. HUSBAND of (or) ~~WIFE of~~: Mamie Kennewig

6 DATE OF BIRTH (month, day, and year): Jan 23 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Philadelphia

PARENTS

10 NAME OF FATHER: Emil Kennewig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eo. Alt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emil Kennewig

(Address) 1943 Patterson Place

15 NOV. 23 1921 ERNEST J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16. 1921 to Nov 21. 1921.

that I last saw him alive on Nov 21 1921,

and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. Kennewig MD

, 19 (Address) 1167 Edmondson Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore City

DATE OF BURIAL: 11/25 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E Hoffman

N. B.—WHITE PAPER, WITH CRIMSON FIBRE. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 58812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58812

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hansen

(a) RESIDENCE. No. 651 Goodyear St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER A. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Alma Snead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Records

(Address) Municipal Hospital

NOV 23 1921

Filed ..... 19.....

.....

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from October 6 , 1921, to November 19 , 1921, that I last saw h[illegible] alive on November 19 , 1921, and that death occurred, on the date stated above, at 12 00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) 1 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) L. P. Bradley, M. D.

11/20/1921 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 23 1921
20 UNDERTAKER	ADDRESS
Geo. H. Deems	1313 Gunther

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58813

64 D 58813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1381 Woodyear ave ST.: 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno Taylor —

(a) RESIDENCE. No. 1381 Woodyear ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Taylor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Nat. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Rebecca Taylor

(Address) 1381 Woodyear Ave

NOV 23 1921

[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/19 — , 1921, to 11/20 — , 1921,

that I last saw h[illegible] alive on 11/20 — 1921,

and that death occurred, on the date stated above, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Paralysis —

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emerick — , M. D.

, 19 (Address) 2129 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Baltimore Cemetery	Nov. 23 1921

20 UNDERTAKER John H. Dennis ADDRESS 313 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58814

CERTIFICATE OF DEATH.

9/100 D 58814

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Benjamin Absher

(a) RESIDENCE. No. 1643 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-27-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Bickhause

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Madelina Absher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed NOV 23 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1921, 19..., to Nov 21, 1921, that I last saw h...alive on Nov 21, 1921, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Laryngitis (not diphtheria)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Horace G. Stewart, M. D.

11/21, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Nov 23 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

A.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58815

CERTIFICATE OF DEATH.

98 D 58815

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Helmick

(a) RESIDENCE. No. 6th st. & Hillcrest ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Helmick

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Columbus Helmick

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Polly Ann Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Records
(Address) M.T.H.

15 Filed NOV 23 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1921, to Nov. 21, 1921, that I last saw him alive on Nov. 21, 1921, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary abscess Duration

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray.

(Signed) Francis L. Dadaglioccio M. D.

11-21-21. 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Nov. 23 1921
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1422 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Probably streptococcus

D 58816 — Dec. [illegible] Co.—1000 Blks.

D 58816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hosp. WARD 18)

2-FULL NAME Doris Stapf

(a) RESIDENCE. No. N. & C. Hosp. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 13th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Albert J. Stapf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Jennie Muhl

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md. (State or country)

11 Informant Albert J. Stapf
(Address) Relay, Md.

15 Filed NOV 23 1921 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3rd, 1921, to Nov 22nd 1921, that I last saw her alive on Nov. 22nd, 1921, and that death occurred, on the date stated above, at 10:20P m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) — yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) — yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. J. Faugler, M. D.

Nov. 19 (Address) 702 E. Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 23rd 1921

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Eden

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58817

CERTIFICATE OF DEATH.

104 D 58817

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Duncan ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Charles Worley

(a) RESIDENCE. NO. 417 S. Duncan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): June 21-1921

7 AGE: Years —; Months 5; Days 1; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Raymond Worley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Theresa Richardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Theresa Worley 417 S. Duncan St.

15 Filed NOV 23 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1921, to Nov. 21, 1921, that I last saw him alive on Nov. 21, 1921, and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Acidosis 4 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Bunglor M. D.

11/22, 1921 (Address) 1100 E. Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent Cem

DATE OF BURIAL: Nov 22 1921.

20 UNDERTAKER: Wendell & Upperman

ADDRESS: 3 [illegible] Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58818

CERTIFICATE OF DEATH.

151 D 58818

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Bruce St.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robert Abery

(a) RESIDENCE. No. 510 Bruce St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Thomas Abery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza J Holden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant
(Address)

15 Filed NOV 23 1921 ROBERT I. BAUTLER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 22, 1921, to Nov 22, 1921, that I last saw him alive on Nov 22 1921 and that death occurred, on the date stated above, at 2 1/2 m.

The CAUSE OF DEATH* was as follows:

Premature birth (6 mos)

20 Min

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R Cassery, M. D.

, 19 (Address) 753 Bonaparte

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 23 1921

Commissioner Health

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58819

D 58819

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1928 E 28th ST., 9 WARD)

2-FULL NAME William G. Jones.

(a) RESIDENCE NO. Cor. Mura & Cecil ton Ave N.W. Cor. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of
~~(or) WIFE of~~ Annie Jones.

6 DATE OF BIRTH (month, day, and year) June. 29 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	29.	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Enamel Worker 086

(b) General nature of industry, business, or establishment in which employed (or employer) Pui Decorating Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. M. Jones.

11 BIRTHPLACE OF FATHER (city or town) Balto Md,
(State or country)

12 MAIDEN NAME OF MOTHER Ida Winkelbach

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Ida M. Jones. 1928 E. 28th St
(Address)

15 Filed NOV 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from November 8 1921 to November 22 1921.

that I last saw h[illegible] alive on Nov 21 1921,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis

(duration) yrs. mos 14 ds. from Pneumonia dating

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cor. Mura & Cecil ton Ave N.W.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Stevens, M. D.

11/22 1921 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 25 1921
20 UNDERTAKER Pirkler & Pirkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58820

CERTIFICATE OF DEATH.

92 D 58820

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Iquatudo

(a) RESIDENCE NO. 1602 E. Hoffman St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4 Months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs Rosario Iquatudo

(Address) 1602 E. Hoffman

15 NOV 23 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1921, to 11-22, 1921, that I last saw h alive on 11-22 1921 and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Over

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. V. Harper M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patrick Cemetery — DATE OF BURIAL Nov 24 1921

20 UNDERTAKER W. Wm. Sr & Smith — ADDRESS 1835 E Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Breast fed about 1½ mos.
Then gave baby pure condensed
milk. This diet caused
malnutrition. No gastro enteritis.
Primary lobar pneumonia.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58821

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 58821

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 N. Gradiera ST.: 7 WARD)

2-FULL NAME Mary Strynek

(a) RESIDENCE. No. 914 N Gradiera ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Strynek

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

11 Informant Mary Geller (Address) 914 N Gradiera St

15 NOV 23 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1921, to Nov 21 1921, that I last saw h alive on Nov 20 1921, and that death occurred, on the date stated above, at 9.30A m.

The CAUSE OF DEATH* was as follows:

Primary Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) M. Strynek, M. D.

11-22 1921 (Address) 900 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 23 1921
20 UNDERTAKER	ADDRESS
Frank Brockdorf	1906 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58822

64 D 58822

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2550 Francis St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Albert Bateman

(Residence in Baltimore: No. 1507 Clifton Ave St. 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Aug (Month) 23 (Day) 1864 (Year)

7-AGE, 57 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Collector
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ames Ry Express

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John A Bateman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Yaalup

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances A Bateman

(Address) 1507 Clifton Ave

15- NOV 23 1921 [redacted] Burial Permit Clerk

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

[illegible]

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

....., 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Nov 25 19 21
20-UNDERTAKER	ADDRESS
Wm Tuckner & Sons	Norfolk Va

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58823

CERTIFICATE OF DEATH.

104 D 58823

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE: (No. 1401 Division ST. 14 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Alfred Freshline

(a) RESIDENCE NO. 1401 Division ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17th 1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Catherine Freshline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant St Vincents Asyl
(Address) 1401 Dennison St

15 Filed NOV 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1921, to Nov 22, 1921, that I last saw he alive on Nov 22, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pelle Cellulosa

(duration) yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. 25 ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas H Claylee M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Nov 23 1921

20 UNDERTAKER E. W. Conklin ADDRESS 924 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of each OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58824

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 D 58824

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3318 Myrtle Pl ST. 76 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Rachel J. Granuith.

(Residence in Baltimore: No. 3318 Myrtle Place Single yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept 4 (Month), 1872 (Year)

7 AGE: 49 yrs. 2 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 93

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Jacariah Barenger

11 BIRTHPLACE OF FATHER (State or country): Balto

12 MAIDEN NAME OF MOTHER: Virginia Cranford

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm G. Granuith.

(Address) 3318 Myrtle Place

15. Robert P. Harrison, 1921 ..... 191 ..... REGISTRAR

OV 23

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November (Month) 22 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 21, 1921, to November 22 1921, that I saw her alive on November 22, 1921, and that death occurred, on the date stated above, at 2.30 p m.
The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Acute Lobar Pneumonia

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) C. T. Bahrenburg M. D.

(Address) 1493, 1921 330 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Nov 1921

20 UNDERTAKER: Wm Cook — ADDRESS: 501 E. Monument

Spec.—1-10-21—M&T—1500 Bks.

Whitted ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58825

CERTIFICATE OF DEATH.

79 D 58825

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 9 Anglewood Rd ST. 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Whitted

(a) RESIDENCE NO. 9 Anglewood Road ST. 27 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Whitted

6 DATE OF BIRTH (month, day, and year) Dec. 9-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Cotton Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER James N. Whitted

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Emeline McKay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Family. Wife Sur
(Address)

15 Filed NOV 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1920, to Nov. 23, 1921, that I last saw him alive on 11 23, 1921, and that death occurred, on the date stated above, at 6 6. m.

The CAUSE OF DEATH* was as follows:

Myocordeial Degeneration

(duration) 3-5 yrs. mos ds.

CONTRIBUTORY (Secondary) Surgical attack

(duration) 1-2 yrs mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry F. Cowdy M. D.

11/23 1921 (Address) Roland Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fayetteville N. C. DATE OF BURIAL Nov 23 1921

20 UNDERTAKER Chas. E. Towner ADDRESS 847 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58826

CERTIFICATE OF DEATH.

D 58826

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Travers

(a) RESIDENCE. No. 623 N. Ch. Harrows Point WARD. Harrows Pt. Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Travers

6 DATE OF BIRTH (month, day, and year) Unknown 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (40)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry C. Travers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed Nov 23 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-19 1921 to 11-21 1921

that I last saw him alive on 11-21 1921

and that death occurred, on the date stated above, at 12 05 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edwin Cowles Andrus, M. D.

11-21 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Nov 24th 1921

20 UNDERTAKER — ADDRESS

Sam'l W. Chase Inc 1400 Mosher

Spec. 6-9-19—H. P. Co.—1000 Bks.

Disposal To Parents

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58827

CERTIFICATE OF DEATH STILL BIRTH

151

D 58827

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 945 W Lexington (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Linton

(a) RESIDENCE. No. 945 W. Lex. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Sgl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/20/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

800

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Robt R Linton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Viola Crabill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant
(Address)

15 Filed NOV 23 1921 [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20/21 19

17 I HEREBY CERTIFY, That I attended deceased from 11/20/21, 19, to 11/20/21, 19,

that I last saw h— alive on 11/20/21, 19,

and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (4½ Mo)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Levy, M. D.

Nov. 23, 1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Disposed of by Parents	19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 58828

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 58828

REGISTERED NO. C.....828

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Robert St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Williams

(Residence in Baltimore: No. 706 Robert St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colored	Widower

6-DATE OF BIRTH: June (Month) 30 (Day) 1904 (Year)

7-AGE: 17 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE (State or country): Bath Md.

PARENTS

10-NAME OF FATHER: Joshua Williams

11-BIRTHPLACE OF FATHER (State or country): Maryland Prince Georges

12-MAIDEN NAME OF MOTHER: Mary J. Johnson

13-BIRTHPLACE OF MOTHER (State or country): Maryland Anne Arundel

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joshua Williams Jenkins

(Address) 706 Robert

15- Filed NOV 24 1921 ..... 19..... Burial Permit ISSUED BY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 21 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to, Nov 21 1921, that I saw h— alive on Nov 21 1921, and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Intercerebral Hem.

(Duration) 1 yrs. 1 mos. ..... ds.

Contributory (SECONDARY) Arteriosclerosis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) C. H. Gordon M. D.

Nov 22, 1921 (Address) 712 S. Wash. Ave.

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Nov 25 1921

20-UNDERTAKER: Jas. Ted Hooper — ADDRESS: 706 N. Conway

HEALTH DEPARTMENT—CITY OF BALTIMORE

58829

CERTIFICATE OF DEATH.

D 58829

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1336 N. Mount St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-FULL NAME Mary C. Johnson

(Residence in Baltimore: No. 1336 N. Mount St.; yrs. 47 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH: November, 1874
(Month) (Day) (Year)

7-AGE: 47 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Jacob Johnson

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Dorcas Kuss

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. M. Johnson

(Address) 1336 N. Mount St.

15- Filed NOV 24 1921 [illegible] Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November, 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Nov. 24, 1921, (Address) 28 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Nov 24, 1921
20-UNDERTAKER James F. Devine	ADDRESS 1303 Gilmor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58830

CERTIFICATE OF DEATH.

18 D 58830

1-PLACE OF DEATH Rosphury md

CITY OF BALTIMORE: (No. 124 Park ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Nellie Hoffman

(a) RESIDENCE NO. 124 Park ave ST., Rosphury md WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleswoman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Coplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Balto st

15 Filed NOV 24 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 (about) 1919, to Nov. 23, 1921,

that I last saw her alive on Oct 24, 1921,

and that death occurred, on the date stated above, at 6.55 m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 2½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Did not Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Symptoms Case)

(Signed) John E. O'Neill, M. D.

11/24 1921 (Address) 827 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cem

DATE OF BURIAL 11/24 1921

20 UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto st

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Letter (over) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58831

CERTIFICATE OF DEATH.

9 | 10 D 58831

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital St. 5 WARD)

2-FULL NAME Mrs. Sarah Finkelstein

(a) RESIDENCE NO. 305 N. Exeter St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write this word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Finkelstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant (Address) Jacob Finkelstein 305 N. Exeter St

15 Filed NOV 24 1921 Registrar

Correction made 2/5/1922 Gotthelf

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-8 -, 1921, to 11-23, 1921,

that I last saw her alive on 11-23, 1921,

and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

1½ hours (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis-Pulmonary Edema (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? Yes Date of 11/20/21

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H.V. Harper, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	11/24 19 21
20 UNDERTAKER	ADDRESS
Jack Levin	1411 E. Balto St

(Over)

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

On 11-21-21 an operation for the reduction of a huge umbilical hernia was performed.

St. Agnes' Hospital,
Baltimore, Md.

#D58831

To St. Agnes Hospital,
Baltimore, Md.

Gentlemen:

Will you kindly change the name of Mrs. Annie Finkelstein, 305 N. Exeter St., City, to Mrs. Sarah Finkelstein, as there was a mistake at the hospital on her admission.

Yours very truly,

Jacob Finkelstein
2 E F.

We have made the necessary corrections on our hospital records
J K B.E. Seegar M.D.

The death certificate was made out by Dr. Caldwell,

dated Nov. 23rd. 1921.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 39 D 58832

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick S. Fowble.

(a) RESIDENCE. NO. Reisterstown. Md ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Anna M. Fowble

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER E. L. Fowble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Ed. C. Hipkin

(Address) Hampstead, Md

15 NOV 24 1921 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to Nov 24, 1921, that I last saw h~~im~~ alive on Nov 24, 1921, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue with Extension to Cervical glands.

(duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Congestion of Lungs.

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Reisterstown Md

Did an operation precede death? No Date of 11/23/21

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John W Mitchell, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emory Chapel	Nov 26 1921

20 UNDERTAKER Wm J Pickett & Sons

ADDRESS North & Penna Aves

Baker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58833

CERTIFICATE OF DEATH.

175 1001 D 58833

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. Mercy Hosp ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fuller Baker

(Residence in Baltimore: No. 1025 Mullin St.; yrs. 7 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Dec 14 1903 (Month) (Day) (Year)

7-AGE. 17 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Operator
(b) General nature of industry, business, or establishment in which employed (or employer): 886

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, W. B. Baker

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER L. M. Kaundel

13-BIRTHPLACE OF MOTHER (State or Country). U. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. B. Baker

(Address) 1025 N. Melton

NOV 25 1921 Filed ....., 191. ... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Ruptured bladder

3 days attd

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Riley M. D.

Nov 24, 1921 (Coroner.) (Address) 1637 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 days ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Catholic Cem	11/26, 1921

20-UNDERTAKER Gr & Jaley ADDRESS 1610 Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58834

CERTIFICATE OF DEATH.

D 58834

REGISTERED No. C 103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Stirling ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma C. Frank

(Residence in Baltimore: No. 607 Stirling St.; 47 yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1874 (Year)

7-AGE, 47 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country). Balto Co. Md

PARENTS.

10-NAME OF FATHER. Jno Jones

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Ciara Zuilka

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Howard.

(Address) 607 Stirling St

15- ROBERT F. BRAUTER

Filed NOV 25 1921 191.... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 22 1921, to Nov. 21 1921, that I saw h[illegible] alive on Nov. 19 1921, and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH* was as follows:

1. Chronic Cardiac Dilatation
(Non valvular)

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Catarrhal Gastritis

(Duration) yrs. 2 mos. ds.

(Signed) W. J. Carr M. D.

Nov. 23, 1921 (Address) 515 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Hill

DATE OF BURIAL, Nov. 25, 1921

20-UNDERTAKER Dennis Easton

ADDRESS 916 Pine

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58835

CERTIFICATE OF DEATH.

58 D 58835

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 866 Vine ST.: 18 WARD)

2-FULL NAME Florence Johnson

(a) RESIDENCE. No. 866 Vine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waco.

PARENTS

10 NAME OF FATHER Wm Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hackley Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wesley Johnson
(Address) 866 Vine

15 Filed NOV 25 1921 19 ... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to Nov. 23, 1921, that I last saw h[illegible] alive on Nov 23, 1921, and that death occurred, on the date stated above, at 10.40 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J. Norwood, M. D.

Nov 25 19 (Address) 989 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 27 1921
20 UNDERTAKER	ADDRESS
Dan'l Easter	916 Pennsylvania

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 58836

CERTIFICATE OF DEATH.

105 D 58836

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bal. Gen. Hosp. St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Wallace

(Residence in Baltimore: No. 1223 Riverside Ave, Curtis Bay. St.: yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, Aug. 4, 1881
(Month) (Day) (Year)

7-AGE, 40 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.? 063

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Lithographer
(b) General nature of industry, business, or establishment in which employed (or employer): American Label Co,

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER, James Wallace

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Adelaide Kelly

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Mathew Freilinger

(Address) 682 Columbia Ave,

15- [illegible]

Filed NOV 25 1921 19[illegible] [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 23, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.
The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Ruptured Duodenal Ulcer

(Duration) ....yrs. ....mos. 7 ds.

(Signed) J. F. Hennessy, M. D.
(Coroner)

Nov. 24, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Bal. Gen. Hosp. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1223 Riverside Ave. (Curtis Bay).

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Leesburg Va.	Nov 25. 1921
20-UNDERTAKER Jos Joerdens Son	ADDRESS 2173 Pa. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58837

CERTIFICATE OF DEATH.

28

D 58837

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3416 Edmondson Av ST.: 16 WARD)

2-FULL NAME Hazel P. Kirn

(a) RESIDENCE. No. 3416 Edmondson Av WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Jan 25 1891

7 AGE: Years 30; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm a Pritchett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah L Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Sarah L. Pritchett

(Address) 3416 Edmondson Ave

15 NOV 25 1921 [illegible] Registrar

Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to Nov 24, 1921, that I last saw her alive on Nov 23, 1921, and that death occurred, on the date stated above, at 12 M m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Wm. D Neill M. D.

11/24 1921 (Address) 108 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — DATE OF BURIAL: Nov 26 1921

20 UNDERTAKER: George J Smith — ADDRESS 1000 E. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58838

CERTIFICATE OF DEATH.

50 D 58838
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Mercy Hospital ST.: 11 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Latimer Hoffman

(a) RESIDENCE. NO. 1001 N. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER James Hoffman
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.
12 MAIDEN NAME OF MOTHER Susan Fulmer
13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mr Tippett
(Address) Walbrook

15 Filed ..., 19 ROBERT J. BRAUER
NOV 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1921, to Nov 24 1921,
that I last saw him alive on Nov 24, 1921,
and that death occurred, on the date stated above, at 1.30 p. m.
The CAUSE OF DEATH* was as follows: Chronic Diabetes
& Myocarditis
(duration) (?) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. 36 mos. ds.

18 Where was disease contracted if not at place of death? Mercy Hospital
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Urine Examination
(Signed) John J Eaton, M. D.
, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 26 1921

20 UNDERTAKER Henry A Jenkins & Sons Co
ADDRESS Orchard & McCulloh Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Brashears)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 58839

CERTIFICATE OF DEATH.

104 D 58839

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 S. Bond ST.: 3 WARD)

2-FULL NAME Henry Howe Brashears

(a) RESIDENCE. No. 322 S. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 3 mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 7-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	20	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Jos Brashears

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Kolb

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Jos Brashears 322 S Bond St

15 Filed NOV 2 1921 19 [illegible] Registrar

[illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1921

17 I HEREBY CERTIFY, That I attended deceased from November 23d, 1921, to November 24th, 1921, that I last saw h[illegible] alive on November 23d, 1921, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Herman Giesing, M. D.

Nov 24, 1921 (Address) 1700 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Brashears~~ ~~Westview~~ Cemetery	Nov 25 1921
20 UNDERTAKER John Herring & Co	ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Itks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58840

CERTIFICATE OF DEATH.

D 58840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: No WARD)

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Smith

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records Municipal Hospital

15 Filed NOV 25 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to November 23, 1921, that I last saw him alive on November 22, 1921, and that death occurred, on the date stated above, at 8 [illegible] m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) per J. A. McKay, M. D.

(Address) Municipal Hospital 11-23/1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Arlington	Nov 26 1921

20 UNDERTAKER John H. Trader ADDRESS 142 Uxbridge

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 ✓ D 58841

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 Baltimore Ave. Rasp[illegible] ST.) (WARD)

2-FULL NAME D. Henry Seifert

(a) RESIDENCE. No. 37 Baltimore Ave. Rasp[illegible] WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Seifert

6 DATE OF BIRTH (month, day, and year) Aug 1st 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Christopher Seifert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Bratmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ida Seifert
(Address) 37 Baltimore ave. Raspburg

15 Filed . 19 ... Registrar

NOV 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 , 19 21 , to Nov 24 , 19 21 , that I last saw h[illegible] alive on Nov 24 , 19 21 , and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma 7

Stomach + (duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Sumwalt , M. D.

Nov 25 1921 (Address) 4706 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov. 26 1921
20 UNDERTAKER	ADDRESS
Frank Lassahn & Sons	Fullerton

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58842

CERTIFICATE OF DEATH.

170 D 58842

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Druid Hill St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Barrett.

(a) RESIDENCE. No. 1024 Druid Hill St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work None 880

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Saml Barrett (Address) 1024 Druid Hill

15 Filed NOV 25 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 19 21, to Nov 23, 19 21, that I last saw h[illegible] alive on Nov 21, 19 21, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Blanchet, M. D.

Nov 24, 19 21 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 25 1921
20 UNDERTAKER John H. Tradum	ADDRESS 142 Whitehall St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mary Warfield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58843

CERTIFICATE OF DEATH.

39 D 58843

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5242 Parrish ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Warfield

(a) RESIDENCE. NO. 524 N Parrish ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 26 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frank Warfield

6 DATE OF BIRTH (month, day, and year) Feb. 14 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) General housework

(c) Name of employer —

9 BIRTHPLACE (city or town) ~~Eastern Shore Md.~~
(State or country) Eastern Shore Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Eastern Shore Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Eastern Shore Md.

14 Informant Frank Warfield
(Address) 5242 Parrish St.

15 NOV 25 1921 [illegible] Registrar

[illegible] BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 , 1921 , to Nov. 23 , 1921 , that I last saw h[illegible] alive on Nov. 22 , 1921 , and that death occurred, on the date stated above, at 8-45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lips, mouth & throat.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy , M. D.

, 19 (Address) 906 N Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MD Auburn Cem	Nov 26 19
20 UNDERTAKER	ADDRESS
A Jones	207 N Stricker St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58844

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Myrtle Place ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Cummings

(a) RESIDENCE. NO. 3411 Myrtle Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Cummings

6 DATE OF BIRTH (month, day, and year) Jan 16 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER M Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Nellie Stolston

(Address) 3411 Myrtle Ave

15 Filed ... 19 ... Registrar

NOV 25 1921 Burial ... Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 1921 to Nov 23 1921.

that I last saw him alive on Nov 22 1921.

and that death occurred, on the date stated above, at 3 30 PM m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 1 mos. 23 ds.

CONTRIBUTORY (Secondary) ... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Isaac W Otney M. D.

Nov 23 1921 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Nov 26 1921
20 UNDERTAKER	ADDRESS
Geo M. Fink & Son	811 N Wolfe

N. B.—WHITE CARDS. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58845

CERTIFICATE OF DEATH.

92 D 58845

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3613 Ash St. ST.: 13 (WARD)

2-FULL NAME Martha L. Murrel

(a) RESIDENCE. NO. 3613 Ash St. ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 4-192[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Gordon C. Murrel

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Paul Minn.

12 MAIDEN NAME OF MOTHER: Myrtle L. Humphrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Laurel Md.

14 Informant (Address): Gordon C. Murrel 3613 Ash St.

15 Filed NOV 25 1921 19[illegible] [illegible] Registrar

Burial permit [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18th, 1921, to Nov 23rd, 1921, that I last saw h[illegible] alive on Nov 23rd, 1921, and that death occurred, on the date stated above, at 5 25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. A. Tillett, M. D.

11/23 1921 (Address) 1527 Linden 1502

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Nov. 25 1921

20 UNDERTAKER: Horace F. Burgee ADDRESS: 3631 Falls Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58846

CERTIFICATE OF DEATH.

79 D 58846

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Guilford Place St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Silas Webster

(Residence in Baltimore: No. 1805 Guilford Pl MW 75 St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec Unknown, 1 (Month) (Day) (Year)

7-AGE, about 63 40 Unknown yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 087

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown Webster

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Webster

(Address) 575 Guilford Ave.

15- NOV 25 1921 Filed 191 ROBERT F. KRAUTER Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary acute cardiac dilatation

(Duration) yrs. mos. ds.

(Signed) W. J. Riley M. D.
(Coroner)

Nov 24, 1921 (Address) 1639 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Millenbeck's Va

DATE OF BURIAL, Nov 25 1921

20-UNDERTAKER George F. Hollar

ADDRESS 63 Druid Hill Ave

(K Leppish)

D 58847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58847

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 822 N. Calhoun St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Constantine T. Kleppisch

(Residence in Baltimore: No. 822 N. Calhoun St. St.; 64 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	Married

6-DATE OF BIRTH. Sept. 15, 1857 (Month) (Day) (Year)

7-AGE. 64 yrs. 2 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION. (a) Trade, profession, or particular kind of work: Clerk (Grocery) (b) General nature of industry, business, or establishment in which employed (or employer): 709

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Chas. F. Kleppisch

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Kleppisch

13-BIRTHPLACE OF MOTHER (State or Country). Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry F. Kleppisch

(Address) 1202 Edmondson Ave

15-

Filed NOV 25 1921 191 JKG Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 23, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ruptured Gall Bladder,

(Duration) yrs. mos. 1 ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Nov. 24. 1921 (Address) 2882 Edmondson Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Hill Park Cem	11-25 1921

20-UNDERTAKER Mrs. Chas. A. S. Rohde

ADDRESS "Arlington Ave

Not traumatic. Probably had gall stones. Cholecystitis finally resulted in rupture & then peritonitis.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58848

D 58848

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1316 Webster St. ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Stubner

(a) RESIDENCE. NO. 1316 Webster St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin E. Stubner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER - - - Zeigler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Franklin E. Stubner

(Address) 1316 Webster St.

15 Filed ~~Dec.~~ 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 25 1921

17

I HEREBY CERTIFY, That I attended deceased from 8/30, 1921, to 11/24, 1921, that I last saw her alive on 11/24, 1921, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical. Urine. Chemical

(Signed) Philip B. Fowler, M. D.

11/25, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 26 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58849

CERTIFICATE OF DEATH.

D 58849

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 W Mon St. 23 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aug. H. Schlippe

(a) RESIDENCE. No. 108 W Mon St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace Schlippe

6 DATE OF BIRTH (month, day, and year): Sept 8 1858

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	63	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Streets dept

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo Schlippe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Michel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant (Address): Vernon Schlippe 108 W Mon St

15 Filed NOV 25 1921 . 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17. 1921. to Nov 24. 1921.

that I last saw h alive on Nov 23. 1921.

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Culture

(Signed) R. K. Campbell M.D.

Nov 24 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 26 1921
20 UNDERTAKER	ADDRESS
Williams	502 E Monte

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58850

CERTIFICATE OF DEATH.

104-091

D 58850

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL. ST.: 11 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Waters

(a) RESIDENCE. NO. 933 Hubbard Alley ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1120

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) child
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) born in Baltimore

PARENTS

10 NAME OF FATHER William Waters
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)
12 MAIDEN NAME OF MOTHER Bertha Waters
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed NOV 25 1921 MOREY & KELLER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17th, 1921, to Nov. 23rd, 1921, that I last saw her alive on Nov. 23rd, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Diarrhoea (not dysentery

(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) Horace G. Stewart, M. D.
11/24, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery — DATE OF BURIAL November 26 1921

20 UNDERTAKER Mrs Robert A Elliott — ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE IS A PERMANENT RECORD. PHYSICIANS should state NAME IN FULL AND ADDRESS EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—I-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58851

D 58851

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S Bethel ST., V WARD)

2-FULL NAME Edward Rodnicki

(a) RESIDENCE NO. 713 S Bethel ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 1 yrs. 3 mos. 24 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ow none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ignacy Rodnicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Sobotka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Ignacy Rodnicki 713 S Bethel

15 Filed NOV 25 1921 H Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1921, to Nov 25, 1921, that I last saw h— alive on Nov 24, 1921, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

1 Acute Gastro Enteritis

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J Hanlon, M. D.

Nov 25, 1921 (Address) J Hanlon MD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 26 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58852

CERTIFICATE OF DEATH.

104 D 58852

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 13 WARD)

2-FULL NAME Edward Orman

(a) RESIDENCE NO. 2439 Maudlow St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. 14 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1/2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jacob Orman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ~~Burial~~ Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1411 E Balto St

15 Filed NOV 25 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/21 19

17 I HEREBY CERTIFY, That I attended deceased from 11/17/21, 19, to 11/24/21, 19.

that I last saw he alive on 11/24/21, 19

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute gastro intestinal indigestion

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1/2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Moses Gilman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Sinai	11/25 19 21
20 UNDERTAKER	ADDRESS
Jack Levis	1411 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58853

CERTIFICATE OF DEATH.

D 58853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 E. Monument St. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Leo Clarkson

(Residence in Baltimore: No. 1830 E. Monument St.

St.: 65 yrs., 11 mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Jan (Month) 21 (Day), 1856 (Year)

7-AGE: 65 yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 050

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: George Clarkson

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md

12-MAIDEN NAME OF MOTHER: Annie Kern

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy E. Clarkson

(Address) 1830 E. Monument

15- ERNEST J. KRAUTER

Filed NOV 25 1921 191.... Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: November (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1921, to November 22 1921, that I saw h[illegible] alive on November 21 1921, and that death occurred, on the date stated above, at 10[illegible] a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 10 yrs....mos....ds.

(Signed) Frank J. Lynch M. D.

Nov 22, 1921 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: Nov 24, 1921

20-UNDERTAKER: William G. Schaeffer

ADDRESS: 1816 Monument

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK. THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 58854

CERTIFICATE OF DEATH

D 58854

Registered No. C 79

1 PLACE OF DEATH

City of Baltimore (No. 806 Gorsuch ave St.: 9 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mona Wilson Lambdin

(Residence in Baltimore: No. 806 Gorsuch Ave St.: 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: July 26, (Month) (Day), 1858 (Year)

7 AGE: 63 yrs. 3 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Printer D63
(b) General nature of industry, business, or establishment in which employed (or employer): Balto News

9 BIRTHPLACE (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Charles W. Landdin

11 BIRTHPLACE OF FATHER (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Alethea Merchant

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Charles Howard Landdin

(Address): Omaha

15 Filed NOV 25 1921 ROBERT I. FRUTZ Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 23, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1918, to Nov. 23, 1921, that I saw him alive on Nov. 23, 1921, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation of the heart

(Duration) 5 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. J. Stuckey Jr M. D.

Nov 24, 1921 (Address) 631 Gorsuch ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Parkwood — DATE OF BURIAL: Nov 26, 1921

20 UNDERTAKER: E. LeRoy Stauffer — ADDRESS: 125 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58855

CERTIFICATE OF DEATH.

157

D 58855

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. City Jail ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Simon or Dikar Maidenovs (Simon) I believe this is proper name

(Residence in Baltimore: No. City Jail St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Unknown

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, Don't Know about 35-40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 089

9-BIRTHPLACE, (State or Country), Supposed Ukrainian

PARENTS.

10-NAME OF FATHER, /

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. Riley

(Address) 1639 N. Broadway

15- NOV 25 1921 ROBERT J. CRAWFORD

Filed ....., 191.... Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, ~~autopsy~~ or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, ~~autopsy~~ or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Strangulation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Riley (Coroner) M. D.

Nov. 22, 1921 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincents Cemetery	Nov. 26 1921

20-UNDERTAKER	ADDRESS
E. J. Fanning & Son	1848 S. Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58856

D 58856

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary Schoenfelder

(Residence in Baltimore: No. 1570 W. Franklin St ST.; 38 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and undertakers are requested to see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 8th (Day), 1857 (Year)

7-AGE, 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Antone Baugman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Annie Shoemaker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oswald Schoenfelder

(Address) 1570 W. Franklin St

15- NOV 25 1921 Burial Permit Clerk.
Filed ..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1921, to Nov 25 1921, that I saw her alive on Nov 25 1921, and that death occurred, on the date stated above, at 3:22 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver

(Duration) —yrs. 2 mos. —ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. Wortley M. D.

Nov 26, 1921 (Address) Franklin Square Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bath Cem. DATE OF BURIAL, Nov 28, 1921

20-UNDERTAKER Philip Herrig ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58857 64 D 58857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N. Collington ave ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Voneiff Sr.

(a) RESIDENCE. No. 419 N. Collington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Minnie Voneiff

6 DATE OF BIRTH (month, day, and year) July 26-51

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Asst.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Voneiff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Minnie Voneiff

(Address) 419 N. Collington ave

15 Date received NOV 25 1921

ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 19 21, to Nov 23, 19 21, that I last saw him alive on Nov 23, 19 21, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Edwin B Lennon M. D.

11/24 1921 (Address) 718 N Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Nov 26 1921
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should send information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58858 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58858

CERTIFICATE OF DEATH.

REGISTERED NO. 71

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Hoffman ST., 10 WARD)

2-FULL NAME John August Miller

(a) RESIDENCE NO. 1026 Hoffman ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John M. Miller

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie L. Grill

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md

14 Informant John M. Miller
(Address) 1026 Hoffman St

15 Filed NOV 25 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 1921, to 11-25, 1921,
that I last saw him alive on 11-25, 1921
and that death occurred, on the date stated above, at 7:45 A. m.
The CAUSE OF DEATH* was as follows:

Convulsions
Cause unknown
Autopsy (duration) yrs. mos 1 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Lotts, M. D.

11/25, 1921 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Nov 28 1921

20 UNDERTAKER Henry Horn Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58859

CERTIFICATE OF DEATH.

9

D 58859

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 2749 Prospect ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Joseph Simms

(a) RESIDENCE. No. 2749 Prospect ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Chld.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 15 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	2	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child) 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fredrick Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Jacobs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Mary Simms
(Address) 2749 Prospect ave.

15 Filed NOV 25 1921 19 LLS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1921, to Nov 25, 1921, that I last saw h... alive on Dec 25, 1921, and that death occurred, on the date stated above, at 7:00 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Nasal exploration. microscopic.

(Signed) H C Grauly, M. D.

, 19 (Address) 1207 Baltimore Trust A

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Nov 26th 1921
20 UNDERTAKER	ADDRESS
William H. Higdon	3824 Oak Ln

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58860

CERTIFICATE OF DEATH.

151 D 58860

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1295 Carrollton Ave ST.: 18 WARD)

2-FULL NAME Paul Shaver.

(a) RESIDENCE. NO. 1295 Carrollton Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	w	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Emanuel Shaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buffalo N.Y.

12 MAIDEN NAME OF MOTHER Cecelia Coleman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Emanuel Shaver
(Address) 1295 Carrollton Ave.

Filed NOV 25 1921 ROBERT I KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1921, to Nov. 25, 1921, that I last saw him alive on Nov. 23, 1921, and that death occurred, on the date stated above, at 7.30a. m.

The CAUSE OF DEATH* was as follows:

Cause unknown.
(Premature baby 7 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) inanition.

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John A. Buchness, M. D.

. 19 (Address) 650 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Nov 25 = 1921
20 UNDERTAKER J. J. Howard & Son	ADDRESS 901 Hollins st

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58861 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58861

150

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Potomac ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter B Lenowith Jr.

(Residence in Baltimore: No. 1235 Potomac St. St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	White	Single

6-DATE OF BIRTH, Nov 18, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ✓ mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 00

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Walter Lenowith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha Tyler

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Lenowith

(Address) 1235 Potomac

15-

Filed ....., 191.... Registrar.

Robert P. Harrison

NOV 25 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1921, to Nov 25 1921, that I saw h... alive on Nov 24 1921, and that death occurred, on the date stated above, at 4. A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) See other side

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Ralph L Hoyt M. D.

....., 191... (Address) 762 Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. DATE OF BURIAL, Nov. 25, 1921.

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58862

HEALTH DEPARTMENT—CITY OF BALTIMORE

50-091 D 58862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 St. Paul St ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rufus King Goodenow

(a) RESIDENCE. No. 813 St Paul St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: President 086

(b) General nature of industry, business, or establishment in which employed (or employer): Canton Lumber Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10 NAME OF FATHER John Goodenow

11 BIRTHPLACE OF FATHER (city or town) (State or country): N H

12 MAIDEN NAME OF MOTHER: Sallie Appleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Mrs Rufus K Goodenow
(Address) 813 St Paul St

15 Filed 19 [Robert P. Harrison] Registrar

NOV 25 1921 [Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 25, 1921, that I last saw him alive on Nov 25 1921, and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 20 yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Necropsy + Lung Exam.

(Signed) J Herman Bruhn, M. D.

19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Nov 28 1921

20 UNDERTAKER: Henry W Jenkins & Son Co.

ADDRESS: Cathedral & Caldcott

N. B.—WRITE PLAINLY. WITH CERTAINTY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58863

CERTIFICATE OF DEATH.

151 D 58863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 N. Linwood ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Smith

(a) RESIDENCE. No. 800 N. Linwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred - yrs. - mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Nov. 19. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	-	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. E. Smith

11 BIRTHPLACE OF FATHER (city or town) Phila. (State or country) Penna.

12 MAIDEN NAME OF MOTHER Sallie Kite

13 BIRTHPLACE OF MOTHER (city or town) Phila. (State or country) Penna.

14 Informant Wm. E. Smith (Address) 800 N. Linwood ave.

15 Filed ..., 19... NOV 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1921, to Nov 24, 1921, that I last saw ~~him~~ alive on Nov 24, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Premature child 5 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) L. Lore, M. D.

11-25-1921 (Address) 2701 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fernwood Cem. Phila. Pa.	Nov. 26 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospital

REGISTERED NO. 28

CITY OF BALTIMORE: (NO. ..... ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fritz Huber

(a) RESIDENCE. NO. 1009 Cherlane ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	W

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	5	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): D67
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: not given

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Hosp. - Records

15 Filed NOV 25 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-1921

17 I HEREBY CERTIFY, That I attended deceased from 11-18-1921, to 11-24-1921, that I last saw him alive on 11-24-1921, and that death occurred, on the date stated above, at 10.60 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6(?) mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? .....

(Signed) Clyde McNeil, M. D.

(Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Nov. 28 1921
20 UNDERTAKER: Fruhlen & Fruhlen	ADDRESS: 1734 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 25 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur C. Porter

(a) RESIDENCE NO. Catonsville Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ohne Auch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Porter
(Address) Catonsville

15 Filed , 19 H. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24 1921

17

I HEREBY CERTIFY, That I attended deceased from 11-23, 1921, to 11-24, 1921, that I last saw him alive on 11-24 1921 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows: Over

General Septicemia
Following Abscess of
Thigh-

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 hrs

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-24-21

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray-Operation-Lab.

(Signed) H. E. Caldwell M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Cemetery	Nov 27 1921
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should state mation should be carefully supplied. AGE that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Slight injury to the knee
from fall.
Not Tuberculous.

Local anesthetic given
for drain.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 58866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 58866

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Donaldson

(a) RESIDENCE. No. 1506 N. Gay St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Sam Donaldson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed: NOV 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from October 7 1921, to November 24 1921, that I last saw him alive on November 24, 1921, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Femur

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/25/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	Nov 28 1921
20 UNDERTAKER	ADDRESS
Robt J Turner	1742 Bway

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58867

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2635 St. Paul ST.: 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Flora Shuttleworth

(a) RESIDENCE. NO. 2635 St Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Household duties

(b) General nature of industry, business, or establishment in which employed (or employer): Ohh

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10 NAME OF FATHER: John H. Shuttleworth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Emma J. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Miss Nina Shuttleworth
(Address) 2635 St Paul St.

15 Filed NOV 25 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1921, to Nov 25, 1921, that I last saw her alive on Nov 24, 1921, and that death occurred, on the date stated above, at 7 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-

(duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Watson, M. D.

Nov 25 1921 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksburg W. Va.	Nov. 28 1921
20 UNDERTAKER	ADDRESS
John C. Mitchell	120 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 58868 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58868

CERTIFICATE OF DEATH. 123

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lardus

(a) RESIDENCE. No. Unknown 1510 Hanover ST., 3 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Poland.

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed ..... 19 .....
Registrar

25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from November 23, 19 21, to November 23, 19 21, that I last saw him alive on November 23, 19 21, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Kidney Stones — Uraemia

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation Shock

(duration) 1/2 hour — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11-23-1921

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) E W Brodrick, M. D.

11/25/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Nov 26 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeller	4033 Wash Blvd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58869

CERTIFICATE OF DEATH.

X 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pope

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD. Weston W. Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? Not Known mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	80	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Formerly a nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Nursing -

(c) Name of employer

9 BIRTHPLACE (city or town) Not Known (State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Ireland (?)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Ireland (?)

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md.

15 Filed 1921 Robert P. Harrison, Burial Permit Clerk, Registrar

V 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22nd 1921. to Nov 25th 1921. that I last saw h alive on Nov 24 1921. and that death occurred, on the date stated above, at 10.50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral (Valve) Disease of the Heart - abt 8 or more (duration) yrs. 0 mos? ds.

CONTRIBUTORY (Secondary) Dementia Senile abt (duration) 8 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Weston W. Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Nov 25. 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Weston - W. Va.	Nov - 25 - 1921.
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

IMPORTANT—PLEASE WRITE WITH CARBON INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58870

CERTIFICATE OF DEATH.

REGISTERED NO. C 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3116 St. Paul St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto J. Hoppe

(Residence in Baltimore: No. 3116 N. Howard ave St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Widower

6-DATE OF BIRTH. Oct 13th, 1845 (Month) (Day) (Year)

7-AGE, 76 yrs. 1 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Day

9-BIRTHPLACE, (State or Country) Leesburg Va.

PARENTS.

10-NAME OF FATHER, Peter Hoppe

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Mary Spring

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fr. Lattacord

(Address) 3116 N. Howard

15-

Filed Nov. 25, 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1921, to Nov 24 1921, that I saw h[illegible] alive on Nov 24 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Progressive Cardiac Degeneration

Several Months at least (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteria Sclerosis

(Duration) 30 or [illegible] yrs. mos. ds.

(Signed) Chas. D. Parker M. D.

11-24, 1921 (Address) 3123 N. Howard ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Nov. 26, 1921

20-UNDERTAKER Wm. Buckler, Hon ADDRESS North Ave

N. B.—Every item of information should be given as exactly supplied. Age should be stated EXACTLY. PHYSICIANS are requested to write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58871

CERTIFICATE OF DEATH.

108 D 58871

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mable Herzog

(a) RESIDENCE. NO. 2772 Druid Hill Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mack Herzog

6 DATE OF BIRTH (month, day, and year) [illegible] 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) " " 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Devereux

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mack Herzog

(Address) 2757 Druid

15 Filed NOV 25 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1921, to Nov. 25, 1921, that I last saw her alive on Nov. 25, 1921, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcerative Colitis

Diabetes Mellitus

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? yes Date of Nov. 22, 1921

Was there an autopsy? yes, partial

What test confirmed diagnosis?

(Signed) Cayetano Lavedrine, M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	11/28 1921
20 UNDERTAKER J Ahrens & Co	ADDRESS 1611 Mad Ave

GENERAL INSTRUCTIONS. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic appendicitis
Gall stones. Cholelithiasis
Operation for cholecystitis
and also gall stones.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58872

CERTIFICATE OF DEATH.

43

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N Kenwood ST.: ~~Ave~~ WARD)

2-FULL NAME Elizabeth R Youngen

(a) RESIDENCE. No. 424 N Kenwood ST. ~~Ave~~ WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Youngen

6 DATE OF BIRTH (month, day, and year) Aug 16 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Rothman
(Address) 424 N Kenwood

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk

V 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1921, to Nov 24, 1921, that I last saw her alive on Nov 21, 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) about yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Appearance of Breast

(Signed) R. J. Cannan, M. D.

11-25-1921 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mathew Cemetery	Nov 26 1921

20 UNDERTAKER Ross C. Miller — ADDRESS 2334 Jefferson St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58873

CERTIFICATE OF DEATH.

108 D 58873

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2629 Boone St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlos J. Kellum

(a) RESIDENCE. No. 2629 Boone St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont know 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oden Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgiana Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Georgiana Brown
(Address) 2629 Boone St

15 Filed Robert P. Harrison, Registrar

V 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1921, to Nov 22, 1921, that I last saw her alive on Nov 22, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute general peritonitis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Catarrhal appendicitis

(duration) ....yrs. ?mos. ?ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Geo. F. Dull, M. D.

, 19 (Address) 426 E. 23 Dot.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov. 26 1921
20 UNDERTAKER James H. Daniels	ADDRESS 1003 Greenmount

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58874

CERTIFICATE OF DEATH.

D 58874

REGISTERED NO. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Division Street ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Banks

(a) RESIDENCE. NO. 1427 Division Street ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Banks

6 DATE OF BIRTH (month, day, and year) September 1891

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Richard Brother

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgetown

12 MAIDEN NAME OF MOTHER Lucy Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Lucy Brother

(Address) 1317 N. Bruce St

15 Filed NOV 25 1921 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24 1921

17

I HEREBY CERTIFY, That I attended deceased from 11/14, 19 21, to 11/24, 19 21, that I last saw h.. alive on 11/24, 19 21, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Ac. Pentonitis over
(Probably from Ruptured Intestine
Case injured 2 yrs. ago)

(duration) yrs. mos. 2 wks ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 27 1921
20 UNDERTAKER James H. Davis	ADDRESS 1503 Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonorrhoeal Salpingitis

D 58875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58875

CERTIFICATE OF DEATH.

X 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital Hospital ST. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Burdette

(Residence in Baltimore: No. (Dundalk) St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Baby

6-DATE OF BIRTH, NOV. (Month) 25 (Day), 1918 (Year)

7-AGE, ... yrs. 11 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, George D. Burdette

11-BIRTHPLACE OF FATHER (State or Country), Lawrance S. C.

12-MAIDEN NAME OF MOTHER Etta L. Sloope

13-BIRTHPLACE OF MOTHER (State or Country), Charlotte N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George B. Burdette

(Address) 83 E Dundalk Ave

15-

Filed ....., 19..

Robert P. Harrison, M.D.

Registrar.

NOV 25 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns accidentally received
War on account of Explosives

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Kirk Pullen M. D.
(Coroner.)

Nov 23, 1921. (Address) Dundalk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Nov 26 1921

20-UNDERTAKER William G. Schaeffer

ADDRESS 816 Monument

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 58876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58876

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE. (No. 1401 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Johnson

(a) RESIDENCE NO. 1401 Division St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1 Nov 1 Nov 1

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant St. Vincent (Address) 1401 Division St

15 Filed ....., 19.... Registrar Robert P. Harrison, Burial Permit Clerk

NOV 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Nov 20, 1921, that I last saw h[illegible] alive on Nov 20 1921, and that death occurred, on the date stated above, at 12 PM m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. Holanthe M. D.

Nov 20, 1921 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Nov 26 1921

20 UNDERTAKER Hartig Fahey & Sons ADDRESS 1827 W North Ave

S. B.—THIS CERTIFICATE, WITH CORRECTIONS, IF ANY, MUST BE RETURNED WITHIN FIVE DAYS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58877

D 58877

CERTIFICATE OF DEATH.

REGISTERED NO. 34

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE: (No. 1401 Division St. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benadette Hutchinson

(a) RESIDENCE NO. 1401 Division St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1921

7 AGE — Years: — Months: 9 Days: 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Earl Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER Gladys Schemm

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant St Vincents (Address) 1401 Division St

15 Filed Nov 26 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

V 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1921, to Mar 23, 1921, that I last saw h. alive on Mar 23, 1921, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) General debility

N.S., (duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Polanders, M. D.

Nov 23, 1921 (Address) 604 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Nov 26 1921

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 822 W North Ave

INFORMATION, WITH CERTIFICATE. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58878

CERTIFICATE OF DEATH.

90 D 58878

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cole - 1st Ave ST., No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Hormann

(a) RESIDENCE NO. Cole Ave & 1st Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karl Hormann

6 DATE OF BIRTH (month, day, and year) Oct 11. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mathilda Entermann

(Address) Cole & 1st Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1924 to Nov. 24, 1924.

that I last saw her alive on Nov. 24, 1921,

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 40 (?) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson M. D.

11/25 1924 (Address) 13 Bel Air Rd, Roslyn.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	Nov. 28 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DV 2 6 1921

(Hancher)

Spec.—1-10-21—M&T—1500 Bks.

D 58879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58879

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret May Hancher

(a) RESIDENCE NO. 337 S 12th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 29, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse 048

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER George T. Hancher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Susan I. West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Lonnie E. Hancher

(Address) 337 S 12th St

15 Filed NOV 26 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 24, 1921,

that I last saw her alive on Nov 20, 1921,

and that death occurred, on the date stated above, at 1 30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No ✓

What test confirmed diagnosis? Blood urea

(Signed) E A Duncan, M. D.

11/24, 1921 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 26 1921

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 26 1921

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58880 D 58880

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeths Home ST.; 9 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Lewis

(Residence in Baltimore: No. St Elizabeths Home Chestnut Hill ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	negro	

6-DATE OF BIRTH, March 14, 1821
(Month) (Day) (Year)

7-AGE, 99 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ppp
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Lewis

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Susie Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Robert F. Harrison,

Filed....., 191.... Registrar.

NOV 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21, to Nov 23 21, that I saw h[illegible] alive on Nov 22 21, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

DTN

Bronchial Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

(Signed) Francis J. Ayd M. D.

Nov 24, 1921 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

NOV 25 1921

Commissioner Health.

1870

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very particular in answering CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Remarks No acute gastro intestinal disturbance. Not premature. Malnutrition due to failure to respond to proper diet. Was born baby.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D 58881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58881

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 415 W. Mulberry ST.; W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Osborne-

(Residence in Baltimore: No. 415 W. Mulberry St.; yrs., 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, April (Month) ..... 23 (Day) ....., 1836 (Year)

7-AGE, 85 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Thos Osborne

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Ann Imbrose

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W. C. Marks

(Address) 1020 Druid Park Drive

15- Robert F. Harrison,

Filed ....., 191..... Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, or~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Heart disease

(Duration) ..... yrs. dont know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. R. Gorsuch M. D.
(Coroner.)

11-26, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hampstead Md.

DATE OF BURIAL, Nov 27, 1921

20-UNDERTAKER W. M. Boutron

ADDRESS 2235 N Howard ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH INK OR INDELIBLE PENCIL.

NOV 26 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58882

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Madison ave ST.: 14 WARD)

2-FULL NAME Lorenzo Bennington

(a) RESIDENCE. No. 1700 Madison ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice B Bennington

6 DATE OF BIRTH (month, day, and year) Feb 15

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	8	9	

8 OCCUPATION OF DECEASED 866

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Bennington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mc Kinnon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W M Routson
(Address) Delta Pa.

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

NOV 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1920, to Nov. 24, 1921, that I last saw him alive on Nov. 24, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) years indefinite mos. ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) [illegible] Stansbury, M. D.

Nov 26 1924 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delta Md.	Nov 28 1924
20 UNDERTAKER	ADDRESS
W M. Routson.	223 N Howard

INFORMATION.—This form is to be filled out in duplicate, and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Daugherty

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., Balto WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Willaim M Daugherty

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	33 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ------

9 BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Balto, Md.

15 Filed ..... 19.... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1921 to Nov 22, 1921, that I last saw him alive on Nov 22, 1921, and that death occurred, on the date stated above, at 6'30 p.m.

The CAUSE OF DEATH* was as follows:

I. Toxic Endocarditis

Nov 8, 1921 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of spine. Tuberculosis of kidney Tuberculosis of bladder (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R. Rayner M. D.
Senior Surgeon (R)
11/22 1921 (Address) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemt — DATE OF BURIAL Nov. 26 1921

20 UNDERTAKER S. Levinson & Bro — ADDRESS 1127 E Baltimore St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST NOT BE FOLDED. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

W 26192

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58884 D 58884

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katharine Fischer

(a) RESIDENCE NO. 243 N. Payson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Husband~~ John Fischer

6 DATE OF BIRTH (month, day, and year) Sept 13 1855

7 AGE: 66 (Years) (Months) (Days) If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ludwig Stail

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Anna Fischer

(Address): 243 N. Payson St

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

V 261921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh hat it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 19 21

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, ..., 19 21, to Nov 28, 19 21.

that I last saw her alive on Nov 26, 19 21.

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Metastasis to Liver

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure fuel- money & disease (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 4-21

Was there an autopsy? Yes

What test confirmed diagnosis? Operation—X Ray

(Signed) W. C. Elwell, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Nov 28 19 21

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 217 S Bond

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 S. Clinton St. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Matilda Hudling

(a) RESIDENCE. No. 618 S. Clinton ST., 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore co. Md.

PARENTS

10 NAME OF FATHER Alois Hudling.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Leocadia Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Alois Hudling.
(Address) 618 S. Clinton St.

15 Filed Nov 26 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 1921 to Nov. 23 1921.

that I last saw her alive on Nov. 22 1921.

and that death occurred, on the date stated above, at 8.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

duration 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & laboratory tests

(Signed) Geo. Keller M. D.

11-25-21 19 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov. 26 1921
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY. WITH LEAD PENCIL OR INDELIBLE PENCIL. PHYSICIANS should state EXACTLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V 26 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58886

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 ✓ D 58886

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Royal Apts Calvert St + Mt Royal Ave ST.) 11 (WARD)

2-FULL NAME. Marion L. Carter

(a) RESIDENCE. No. Mt. Royal Apartments ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John B. Carter

6 DATE OF BIRTH (month, day, and year) Feby 6th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Maria Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs Carter
(Address) Mt Royal Apts

15 Filed NOV 26 1921 Robert P. Barrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from 7.45 A.m. Nov 25, 1921, to 7.45 A.m. Nov 25, 1921, that I last saw her alive on Nov 25. 7.45 A.m. 1921, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

a few hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General ill health for some months (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Mifflen, M. D.

, 19 (Address) 2070 16 Mad. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	11/28 1921

20 UNDERTAKER Chas E. Evans & Son ADDRESS 118 W Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 26 1921

D 58887 HEALTH DEPARTMENT—CITY OF BALTIMORE 15 IV D 58887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE (No.) Lake ave. & Falls Road St. Washington (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Carr

(Residence in Baltimore: No.) Lake ave & Falls Road (St.; yrs., 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (~~Write the word.~~)
F	Wh	Single

6-DATE OF BIRTH. Sept. 7, 1921 (Month) (Day) (Year)

7-AGE. ....yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank Carr

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Ida Gaunt

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Carr

(Address).....

15- Nov 26 1921 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov. 24, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Robt P. Harrison M. D. (Coroner.)

Nov 26, 1921 (Address) 3122 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys Hampden	Nov 26, 1921
20-UNDERTAKER	ADDRESS
Chenowith & Son	Chestnut &

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58888

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58888

CERTIFICATE OF DEATH.

115

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. Lombard & Green ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Ruby

(a) RESIDENCE. No. 2816 Huntington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Wm. V. Ruby.

6 DATE OF BIRTH (month, day, and year) ? 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Elijah Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Husband.
(Address) 2816 Huntington Ave

15 Filed NOV 26 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-31, 1921, to 11-25-, 1921, that I last saw h alive on 11-25-21, 1921, and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows:

Stone in Common bile Duct. with Obstruction.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Jaundice with anemia & hemorrhages in tissues (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 1921

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) F. G. Holden, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 28 1921
20 UNDERTAKER	ADDRESS
Ehrenworth Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by the Registrar. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58889

CERTIFICATE OF DEATH.

120 D 58889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ora Tyson

(a) RESIDENCE. No. 619 Union Ave Woodbury ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Tyson

6 DATE OF BIRTH (month, day, and year) June 12 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thos Driggetta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Arrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Driggetta

(Address) 3642 Ash St

15 Filed 19 Robert P. Harrison, Registrar

NOV 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 23, 1921, to Nov 26, 1921, that I last saw he alive on Nov 26, 1921, and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

toxemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Vernon J. Kelly, M. D.

(Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 29 1921

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut

S. B.—WRITE PLAINLY. Matter printed in italics should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58890

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 D 58890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 410 Belnord St.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Virginia Starkey

(Residence in Baltimore: No. 410 Belnord St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE, Wh.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Bay

6-DATE OF BIRTH, Nov. (Month) 19 (Day) 21 (Year)

7-AGE. ....yrs. ....mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).... 00

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Wm. P. Starkey

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Lena Schedel

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. P. Starkey

(Address) 410 N. Belnord

15-

Robert P. Harrison,

Filed ....., 191....

Registrar.

NOV 26 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Kirk Sneeden M. D. (Coroner)

11-26, 1921 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem

DATE OF BURIAL, Nov. 26, 1921.

20-UNDERTAKER Jos. J. Herr

ADDRESS 156 N. Luzerne ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58891

64-9 D 58891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Preston) Lucas

(a) RESIDENCE. No. 1233 W. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, (Widowed,) or ~~Divorced~~ (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records
(Address) Municipal Hospital

15 Filed 1921 Robert P. Harrison
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23 1921

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1921, to November 23, 1921, that I last saw h[illegible] alive on November 22, 1921, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Mowell, M. D.

11-23-1921 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 2 1921
20 UNDERTAKER	ADDRESS
Commissioner Health.	

N. B.—THESE BLANKS, when properly filled out, CONTAIN THE RECORD OF DEATH. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HARRIS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58892

CERTIFICATE OF DEATH.

151

D 58892

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE: (No. 1807 Belt Ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Jarvis Harris

(Residence in Baltimore: No. 1807 Belt Ave St.; ..... yrs., ... mos. 3½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Nov. 22 (Month) (Day), 1921 (Year)

7-AGE.	If LESS than 1 day,
0 yrs. 0 mos. 3½ ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....—....
(b) General nature of industry, business, or establishment in which employed (or employer) ....—....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. David Richard Harris

11-BIRTHPLACE OF FATHER (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER Lillie Mae Denton

13-BIRTHPLACE OF MOTHER (State or Country). N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David R. Harris

(Address) 1807 Belt Ave

15-

Filed ..... 191.. Robert P. Harrison, Registrar.

W 261921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26 (Month) (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1921, to Nov 26 1921, that I saw him alive on Nov 26 1921, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Premature birth - 6½ months

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. C. Johnson M. D.

11-26-21, 1921. (Address) Balto. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Fairview Cem. Baltimore	Nov 28, 1921.
20-UNDERTAKER	**ADDRESS**
Mrs. E. Eleanor Sons	1120 Stricker St

15

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47

D 58893

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Roeder

(a) RESIDENCE. No. 2432 Druid Hill Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Charles Roeder

6 DATE OF BIRTH (month, day, and year): Feb 22, 1882

7 AGE: Years 39 Months 9 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Timothy Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records

(Address)

15 Filed ....., 19.....

Registrar

Burial Permit Clerk

NOV 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Nov 25, 1921,

that I last saw her alive on Nov 25, 1921,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Endocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (secondary) Cerebral apoplexy (Embolic) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs Symptoms

(Signed) John J. Brown, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 28 1921

20 UNDERTAKER: Harry H. Wiltz Co — ADDRESS: 1531 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCU CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

58894 HEALTH DEPARTMENT—CITY OF BALTIMORE 58894

D 58894 CERTIFICATE OF DEATH. D 58894

1-PLACE OF DEATH REGISTERED No. C

CITY OF BALTIMORE (No.) Mercy Hospital ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Monaghan Conaghan

(Residence in Baltimore: No. New York. (Imp. res. 119 Decatur St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, about 65 Years. Done on dated 6-3 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Germany

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address).....

15- Filed NOV 27 1921 19..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart

Duration 1 hour

CONTRIBUTORY (Secondary) Pulmonary Edema. Duration 2 hours yrs. mos. ds.

(Signed) A. J. Riley M. D. (Coroner.)

Nov 26, 1921 (Address) 1639 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New York City	Nov 29, 1921
20-UNDERTAKER	ADDRESS
E. J. Fanning & Son	1938 E. Lafayette Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 58895

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N Washington ST.; 6 WARD)

2-FULL NAME Sophie Kreamer

(a) RESIDENCE. No. 205 N. Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4/ yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emil Kreamer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Kotter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Emil Kreamer

(Address) 205 N Washington St

15 NOV 27 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 1921 to Nov. 24 1921, that I last saw her alive on Nov 24 1921, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Allen Cushing M. D.

, 19 (Address) 2027 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 29 1921

20 UNDERTAKER Emil Groetzinger

ADDRESS 1906 Eutaw

DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(OK) L. C. Blades Md D 58896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58896

CERTIFICATE OF DEATH.

Coroner at Large
acting S. H. O.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
(Railroad Ave)
CITY OF BALTIMORE: (No. Mount Hermon Md ST., 45 WARD)

2-FULL NAME Joseph Huston.

(a) RESIDENCE. (No. Mount Hermon ST., Md WARD.
(Usual place of abode) Railroad Ave
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): no occupation past several months.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS
10 NAME OF FATHER: Stephen Huston
11 BIRTHPLACE OF FATHER (city or town) (State or country): So. Carolina
12 MAIDEN NAME OF MOTHER: Sarah Carter
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Emma Harris
(Address) Railroad Ave Mt Hermon

15 Filed NOV 21 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1921, to Nov. 10, 1921
(in dispensary)
that I last saw him alive on Nov. 23, 1921
and that death occurred, on the date stated above, at 8:15 a.m.
came to dispensary from Nov 10 - Nov 23 1921
The CAUSE OF DEATH* was as follows:
Adenocarcinoma of antrum
Glands of neck
(suppurative)
(duration) (?) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cachexia (Carcinoma) (2 months)
Failure (duration) (2 hr) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (Opening of drainage ?
Glands of neck
Did an operation precede death? yes Date of Oct 6 1921
Was there an autopsy? no
What test confirmed diagnosis? Finding of tumor Symptoms Subsequent
(Signed) John J Ewin, M. D.
. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 27 1921
20 UNDERTAKER	ADDRESS
Samuel L Hawley	N Bdle

Registrar's Record Check

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58897 ✓ 156 D 58897

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 30 E. Baltimore St. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frank. Merriken Jr.

(Residence in Baltimore: No. 1807 Portland Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Aug. 16, 1890 (Month) (Day) (Year)

7-AGE, 31 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Trucker Engraver
(b) General nature of industry, business, or establishment in which employed (or employer): Lino

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frank Merriken Sr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Kate E. Sass

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Moran

(Address) 300 E Baltoh

15-

Filed NOV 27 1921 191.... SCELLA & KLAUER

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

/

Lucid by Illuminating Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) W. F. Riley (Coroner.) M. D.

Nov. 27, 1921. (Address) 6 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, 11-28, 1921

20-UNDERTAKER J. J. Moran ADDRESS 300 E Baltoh.

Margaret Wolferman.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58898

CERTIFICATE OF DEATH.

17V D 58898

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 So Hasel ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Wolferman

(Residence in Baltimore: No. 456 n Lemmond av 60 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec 9, 1839 (Month) (Day) (Year)

7-AGE 81 yrs. 11 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Linta

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lorence

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... F. H. Sange

(Address)..... Hamilton Md

NOV 27 1921

Filed....., 191.....

ROBERT J. GRAVES Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 19 21 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) C. Ross Snader M. D. (Coroner.)

11-26-, 191.. (Address) 456 N Lemmond av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Tanenuels Cemetery	Nov. 28., 19 21
20-UNDERTAKER	ADDRESS
Louis Heeman	32 S Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58899

D 58899

CERTIFICATE OF DEATH.

71

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 S Bethel ST., 7 WARD)

2-FULL NAME Victoria Skarzynska

(a) RESIDENCE NO. 724 S Bethel ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8 1921

7 AGE — Years: — Months: 6 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bronislaw Skarzynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Zajac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Bronislaw Skarzynski
(Address) 724 S Bethel

15 Filed NOV 27 1921 BUREAU OF STATISTICS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1921, to Nov 26, 1921, that I last saw h[er] alive on Nov 26, 1921, and that death occurred, on the date stated above, at 5300 m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions
due to Overfeeding,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Nov 26, 1921 (Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Nov 27 1921

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Eutaw St

N. B.—BOTH PHYSICIAN AND UNDERTAKER should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58900

D 58900

X 173

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Priscilla Hall

(a) RESIDENCE. NO. Rising Sun Md. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John A. Hall

6 DATE OF BIRTH (month, day, and year) March 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER Wm. Kyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Nancy Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Patient (Priscilla Hall) Rising Sun

(Address)

15 Filed NOV 27 1921 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Nov 27, 1921, that I last saw h.e.l. alive on Nov 27, 1921, and that death occurred, on the date stated above, at 1:25 A. m.

The CAUSE OF DEATH* was as follows:

Renal Lithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Nov 19, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Eric L. Wiesig, M. D.

19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL

Ebenezer Cecil County Md. Nov 30 1921

20 UNDERTAKER — ADDRESS

Harry H. Witzke 1531 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58901

CERTIFICATE OF DEATH.

109 D 58901

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Brown Zywicka

(a) RESIDENCE. No. 907 South East ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13 1867.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54.	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany - Poland

PARENTS

10 NAME OF FATHER Karol Archer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Poland

12 MAIDEN NAME OF MOTHER Barbara Rickard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) James Zywicki 907 S. East Ave

15 Filed NOV 27 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1921, to Nov 25, 1921, that I last saw h[illegible] alive on Nov 25, 1921, and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

Umbilical Hernia
Strangulated.

(duration) 24 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxemia. Cardiac Failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 907 South East ave.

Did an operation precede death? Yes Date of Nov 25. 1921

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Nobel W Mitchell, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Nov. 27 1921
20 UNDERTAKER	ADDRESS
Stephen F Falkowski	1005 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58902

CERTIFICATE OF DEATH.

150 D 58902

1-PLACE OF DEATH Robert Garrett Hospital REGISTERED No. C

CITY OF BALTIMORE: (No. ~~611 Kirby Lane~~ ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Brogan

(Residence in Baltimore: No. 611 Kirby Lane St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, Nov 24 1921, 1
(Month) (Day) (Year)

7-AGE, ..yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George W. Brogan

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER Viola V. Simms

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. George Brogan

(Address) 611 Kirby Lane

15- Filed NOV 27 1921 ROBT. J. SLATER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25 1921, to Nov. 26 1921, that I saw him alive on Nov. 25, 1921, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Catarrh Stomach Malo

(Duration) ..yrs. ..mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ..yrs. ..mos. ..ds.

(Signed) J. T. Heneman M. D.

Nov 26, 1921. (Address) 2802 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Robt Garrett Hosp yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 611 Kirby Lane

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Nov 27, 1921

20-UNDERTAKER Jno Joerdens & Son

ADDRESS 27 S. Paca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 58903

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 S 12½ St. ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Boyce

(Residence in Baltimore: No. 627 S 12½ St. St.; ..... yrs., 10 mos. 26 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S entries must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Dec (Month) 31 (Day), 1920 (Year)

7-AGE, ... yrs. 10 mos. 24 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER, Clifton Boyce

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Elsie Kidwell

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elsie Boyce

(Address) 627 S - 12½ St.

15- Filed NOV 27 1921 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1921, to Nov 26 1921, that I saw h-w alive on Nov 25 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Ex Lamotomie .....

.....

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Enteritis - Colitis

..... (Duration) ..... yrs. ..... mos. 18 ds.

(Signed) Ralph L Wright M. D.

11/26, 1921. (Address) 26 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel - DATE OF BURIAL, Nov 28..., 1921.

20-UNDERTAKER Wm Cook 502 E. ADDRESS North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58904

CERTIFICATE OF DEATH.

64 D 58904

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital ST. Weiler & Tellman WARD 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Sandlass

(a) RESIDENCE. No. 1635 Friendship ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. F. Sandlass

6 DATE OF BIRTH (month, day, and year) Dec. 25 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Michael Gavigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Ire~~ Scotland

12 MAIDEN NAME OF MOTHER Virginia -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Geo. F. Sandlass
(Address) 1635 Friendship Parkway St

15 Filed NOV 27 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-25 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1921, to Nov 25, 1921, that I last saw her alive on Nov 24, 1921, and that death occurred, on the date stated above, at 8.15 Am.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Cerebral Haemmorhage
Acute Dilatation Heart

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Haemmorhage Acute Dilatation Heart (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 1635 Friendship Pkwy

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A Hetherington, M. D.

, 19 (Address) 1807 No Howard ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov. 28, 1921
20 UNDERTAKER Wm Cook	ADDRESS 502 E. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58905 — 28 — D 58905

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

2-FULL NAME Joseph O'Brien

(a) RESIDENCE. No. 830 N. Stricker st. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Edward O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rachel Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Hospital Records M.T.H.

15 NOV 27 1921 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to Nov. 25, 1921, that I last saw him alive on Nov. 25, 1921, and that death occurred, on the date stated above, at 4.25 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Badgley M. D.

11-25-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Nov 29 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

N. B.—WRITE PLAINLY. ALL BLANKS should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58906

CERTIFICATE OF DEATH.

D 58906

REGISTERED NO.

1-PLACE OF DEATH (Hamilton)

CITY OF BALTIMORE: (No. 1 Carter Ave ST. 47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Martha S. Brannan

(a) RESIDENCE. NO. 1 Carter Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

GE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Adila Brannan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hunterstown, Pa.
(State or country) Watson, Del.

PARENTS

10 NAME OF FATHER Chas. M. Service

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Philadelphia, Pa.

12 MAIDEN NAME OF MOTHER Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Missouri

14 Informant Katherine I. Brannan
(Address) 1 Carter Ave

15 Filed NOV 27 1921 BOARD OF HEALTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to Nov 25, 1921, that I last saw her alive on Nov 25, 1921 and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

about (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

11/26 1921 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Nov 28/ 1921

20 UNDERTAKER Wm. Cook.

ADDRESS 502 E. North Ave

D 58907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 58907

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1629 Asquith St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Stemmons

(Residence in Baltimore: No. 1629 Asquith St. 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (*Write* the word.): Married

6-DATE OF BIRTH: Nov. (Month) 6 (Day), 1852 (Year)

7-AGE: 69 yrs. 18 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country): Philadelphia Pa

PARENTS.

10-NAME OF FATHER: William Stemmons

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Margaret Unger

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Stemmons

(Address) 1629 Asquith St

15-

Filed NOV 27 1921 191 BOARD OF HEALTH BALTIMORE MD. (Registrar)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.) M. D.

, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Chester Pa

DATE OF BURIAL, Nov 28, 1921

20-UNDERTAKER: William Lack

ADDRESS: 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58908

CERTIFICATE OF DEATH.

D 58908

REGISTERED NO. 1

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Benton

(a) RESIDENCE. No. 1722 W. Lanvale St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH CARE AND PHYSICIANS should state EXACTLY. AGE should be stated mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James S. Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Lillie Messick.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant James S. Benton
(Address) 1722 W. Lanvale St.

15 Filed NOV 27 1921 [illegible] Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1921, to Nov. 27, 1921, that I last saw h[illegible]live on Nov. 27, 1921, and that death occurred, on the date stated above, at 4.40 a m.

The CAUSE OF DEATH* was as follows:

Perforated ulcer, by hour of duration with general peritonitis (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Typhoid fever (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? 1722 W. Lanvale St

Did an operation precede death? yes Date of Nov. 18, 1921

Was there an autopsy? Partial Autopsy

What test confirmed diagnosis? Surgical findings & autopsy

(Signed) Cyrus J. Horine, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastern Shore Mem	Nov 29 191
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E. North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58909

CERTIFICATE OF DEATH.

151 D 58909

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 S. Madeira St.: 1 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Fischer

(a) RESIDENCE. No. 421 S. Madeira St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 21 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Bernard Fischer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Kunegunda Gumm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Bernard Fischer
(Address) 421 S Madeira St

15 Filed NOV 27 1921 19 Registered

ROBERT I KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 26th, 1921, to Nov. 27th, 1921, that I last saw h[im] alive on Nov. 26th, 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart - failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth (8 mo)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jennie N. Browne, M. D.

Nov 27 1921 (Address) 510 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov. 28 1921
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe

N. B.—WRITE PLAINLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58910

CERTIFICATE OF DEATH.

181 D 58910

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. South Plant Balto. Dry Docks St. Co WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Spinato.

(Residence in Baltimore: No. 511 S. Linwood Ave. St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, August 6th. 1898., 1 (Month) (Day) (Year)

7-AGE, 23 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pipe fitter
(b) General nature of industry, business, or establishment in which employed (or employer): helper

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Michael Spinato.

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Catherine Maiorana.

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwars Costanza.

(Address) 606 S. Curley St.

15- Filed NOV 27 1921 19... Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 24th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted.

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs...mos...ds.

(Signed) Otto K. Rowland M. D. (Coroner)

Nov. 27, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Nov. 28, 1921
20-UNDERTAKER	ADDRESS
Lilly & Zile	403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

58911 D 58911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 58911

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 N. Hoffman ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Murdock

(a) RESIDENCE NO. 532 N Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaiah Murdock

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sallie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Noah F. Murdock

(Address) 532 N Hoffman St

15 NOV 27 1921 BOARD OF HEALTH Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23d, 1921, to Nov. 25th, 1921, that I last saw h[illegible] alive on Nov. 25th, 1921, and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows: Broncho-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Fibroid Growth

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Signs in Lungs.

(Signed) A. Lee Ellis M. D.

11/25, 1921 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Nov 28 1921

20 UNDERTAKER Clement Hall — ADDRESS 909 Hollen St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

175-001 D 58912

REGISTERED NO. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. St. Josp. Hosp ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Priscilla Seeburger

(Residence in Baltimore: No. 1803 N Regester Street) (If LESS than 1 day, ... hrs. ... mins.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1912 (Year)

7-AGE, 9 yrs. mos. ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): Pupil

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER, John F. Seeburger

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Barbara Shlee

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John F. Seeburger
(Address) 1803 N. Regester st

15- FILED NOV 28 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Traumatic Epi
Ag Auto (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. Engler M. D. (Coroner.)
, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemetery	Nov 28, 1921
20-UNDERTAKER	ADDRESS
George J. Ruth	1735 Hanford Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH INK.

April 15.

Spec. 4-9-19—H. P. Co.—1000 Bks.

D 58913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58913

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Bachman

(a) RESIDENCE. NO. 1403 N. Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Femal	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Bachman.

6 DATE OF BIRTH (month, day, and year) April 15-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House 037

(b) General nature of industry, business, or establishment in which employed (or employer) Wife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Henry Swartz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Germany.

14 Informant (Address) Mrs N. Bachman 1403 N. Caroline at

15 NOV 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1921, to Nov 24, 1921, that I last saw her alive on Nov 24, 1921, and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov. 24, 21

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Frank C. Marcus, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov 28 1921
20 UNDERTAKER George L. Ruth	ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58914

76 D 58914

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 103 S. Robinson ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Spear

(a) RESIDENCE. No. 103 S. Robinson ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/27/1917

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	4 ~~5~~	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Wm. A. Spear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura E. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs. Wm. Spear 103 S. Robinson St

15 Filed . 19 Registrar

NOV 28 1921

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/19 . 1921 . to 11/27 . 1921 .
that I last saw her alive on 11/26 . 1921 .
and that death occurred, on the date stated above, at 1.50 p. m.
The CAUSE OF DEATH* was as follows:

Otitis media dextra
Chronic suppurating.
(duration) yrs. mos. 9 dys.

CONTRIBUTORY (Secondary) Streptococcic Meningitis
(duration) yrs. mos. 5 dys.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture with culture & Path. Exam.

(Signed) Geo. Baughman, M. D.

11/27, 1921. (Address) 1517 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dorchester County Cem. DATE OF BURIAL: 11/29/1921

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58915

CERTIFICATE OF DEATH.

D 58915

REGISTERED NO. 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S. Patterson Park Ave. WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul H. Schmatz

(a) RESIDENCE No 116 S. Patterson Park Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Schmatz

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	58	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Stuttgart Germany

PARENTS

10 NAME OF FATHER J.P. Schmatz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Ehnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Schmatz (Address) 116 S. Patterson Park Ave.

15 Filed NOV 28 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from November 21st, 1921, to Nov. 25th, 1921, that I last saw h[illegible] alive on November 24th, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fenton J. Gruning, M. D.

Nov 26, 1921 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Cemetery	Nov. 29 1921
20 UNDERTAKER	**ADDRESS**
H. Sander Sons	1710 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58916

CERTIFICATE OF DEATH.

89 D 58916

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 106 Cold Spring Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda Melvina Ramsey

(Residence in Baltimore: No. 106 Cold Spring Ave St.; 84 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1837 (Year)

7-AGE, 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, — Rolls

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cora Rodnick

(Address) 106 Cold Spring Ave

15-

Filed ....., 191.... Registrar.

NOV 28 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 7 1921, to November 26 1921, that I saw her alive on November 26 191..., and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) H. H. Stansbury M. D.

Nov. 27, 1921. (Address) 714 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Nov. 29, 1921

20-UNDERTAKER Chas. E. Cranck

ADDRESS 801 Madison Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D [redacted] D58917 D58917 D [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4322 Eager ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Robert Grimes

(a) RESIDENCE. NO. 4322 Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Grimes

6 DATE OF BIRTH (month, day, and year) Nov 11, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer 073
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Penn R R

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thomas C Grimes
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.
12 MAIDEN NAME OF MOTHER Sara Gorsuch
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Catherine Grimes
(Address) 4322 E. Eager St

15 Filed NOV 28 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 21st, 1921, to Nov 27th, 1921, that I last saw him alive on Nov 27, 1921, and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pleurisy (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Ford, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL Nov 28 19 21

20 UNDERTAKER E. Le Roy Stiffler

ADDRESS 125 E North ave

D 58918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 58918

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3110 Edmondson Ave ST.: 12 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hudson

(Residence in Baltimore: No. 3110 Edmondson Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, Nov 26, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Hobart Hudson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co.

12-MAIDEN NAME OF MOTHER May Williams

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hobart Hudson

(Address) 3110 Edmondson Ave

15- [illegible]

Filed NOV 28 1921 191 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
(Coroner)

Nov 27, 1921 (Address) 302 Colonial Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Nov 28, 1921
20-UNDERTAKER E. L. Roy Stiffler	ADDRESS 125 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 58919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 48

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Liebman

(a) RESIDENCE. NO. 1264 Spring st Monell Park ST., WARD. Baltimore Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Liebman

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Eng. Instrument Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Liebman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Maud Liebmann
(Address) 1264 Spring st Monell Park

15 Filed NOV 28 1921 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 1921 to Nov 23 1921, that I last saw h in alive on Nov 23 1921, and that death occurred, on the date stated above, at 3.35 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1264 Spring st Monell Pk

Did an operation precede death? Yes Date of Nov 13, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Kelly, M. D.

, 19 (Address) 1111 Jones Falls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov 28th 1921
20 UNDERTAKER	ADDRESS
John J Fallon	1208 W Fayette st

N. B.—WRITE PLAINLY WITH INK AND AVOID ERASURES. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58920

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 22 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Downey Taylor

(a) RESIDENCE. No. 657 W. Pratt St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dollie Taylor

6 DATE OF BIRTH (month, day, and year) Aug 14 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co., Maryland

PARENTS

10 NAME OF FATHER John Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co., Maryland

12 MAIDEN NAME OF MOTHER Sally Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co., Maryland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed NOV 28 1921 ROBERT P. BRAUTE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from November 2, 1921, to November 24, 1921, that I last saw her alive on November 24, 1921, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. T. Bradley, M. D.

11/25/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Nov 28 1921

20 UNDERTAKER Joseph R. Cook ADDRESS 1103 W. Balto St

NOTICE IS HEREBY GIVEN THAT THE REPORT OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spes. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58921

CERTIFICATE OF DEATH.

120 D 58921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N. Pulaski St. ST.: 20 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Allen

(a) RESIDENCE. NO. 306 N. Pulaski St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Allen

6 DATE OF BIRTH (month, day, and year) Nov. 14" 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Lanthern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John H. Posther
(Address) 306 N. Pulaski St.

15 Filed . 19 [illegible] Registrar

NOV 28 1921 Baltic [illegible] Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25" 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 19 21 to Nov 25 19 25

that I last saw her alive on Nov 21 19 ,

and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Uremia.
Pulmonary Odema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy Dwelley M. D.

11/26 24 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emerald Cem. (Eldridge)	Nov 28 1921

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Eutaw St

IMPORTANT: This is a LEGAL RECORD. Data entered must be complete and accurate. Before making any statement, see that you have the facts. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58922

CERTIFICATE OF DEATH.

9 D 58922

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 N. Glover ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose White

(Residence in Baltimore: No. 128 N. Glover St. St.: 5 yrs., 5 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 3, 1916 (Month) (Day) (Year)

7-AGE, 5 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas W. White

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Anna Bayer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Thomas Pugh

(Address) 128 N. Glover St.

15- NOV 28 1921 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18 1921, to Nov 27 1921, that I saw h[er] alive on Nov. 26 1921, and that death occurred, on the date stated above, at 11 55 A. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dysentery a

(Duration) ..... yrs. ..... mos. 13 ds.

(Signed) Geo Keller M. D.

11-27-, 21 (Address) 1937 Gough St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 28, 1921

20-UNDERTAKER Henry Lutz — ADDRESS 1203 W. Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58923

CERTIFICATE OF DEATH.

92-114

D 58923

REGISTERED NO.

1-PLACE OF DEATH Church Home & Inf.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST.: 13 WARD)

2-FULL NAME Mr. William Chandler

(a) RESIDENCE. No. 606 N. North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Grace H Chandler

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer Can Co

9 BIRTHPLACE (city or town) (State or country) Ky

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dr Malden Crawford

(Address) 606 N North Ave

15 NOV 28 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 19 21, to Nov 27, 19 21, that I last saw h~~im~~ alive on Nov 27, 19 21, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

1 Cholecystitis, Chronic

2 Cholelithiasis

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary) Pneumonia, Lobar, Rt

(duration) yrs. mos. 3 days ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 23. 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H B Wood, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 29 1921

20 UNDERTAKER Williams Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

D 58924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-154

D 58924

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 N. Charles St ST., 11 WARD)

2-FULL NAME Anne Johnson Poe

(a) RESIDENCE NO. 1204 N. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Poe

6 DATE OF BIRTH (month, day, and year) May 22nd 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	81	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Hopkins Hough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaretta Johnson Nov 26th 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Eugene allen Poe
(Address) 1204 N. Charles St

15 NOV 28 1921 BURKE & TOUTE Burial Permit Issued (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1911, 19 ....., to Nov. 26th, 1921, that I last saw h.e alive on Nov. 26th, 1921, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. M. Dabney, M. D.

Nov 26th 1921 (Address) Reston Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Nov 28 1921

20 UNDERTAKER: Henry H. Jenkins Sons Co — ADDRESS: McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be answered. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Sena Sugar.

D 58925 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument St. ST. 10 WARD)

REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sena Sugar

(a) RESIDENCE NO. 1100 N Caroline ST., ... WARD 8
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Sugar

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE: Years 29 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 137
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Hyman Sperok

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Anna Farfel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Louis
(Address): 1411 E Baltimore St

15 Filed NOV 28 1921 ROBERT I. FRAZIER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Nov 27, 1921, that I last saw her alive on Nov 27, 1921, and that death occurred, on the date stated above, at 4 40 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Fever

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) General Sarcomatosis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 24, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

Nov. 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Sinai — DATE OF BURIAL: 11/28 1921

20 UNDERTAKER: Jack Louis — ADDRESS: 1411 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

(Approved by U. S. Census and American Public Health Asso.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Originated in abdominal wall.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58926

CERTIFICATE OF DEATH.

D 58926

1-PLACE OF DEATH
CITY OF BALTIMORE (No. S.E. Cor. Ridgely & Rusk Aves.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P. Koerner

(Residence in Baltimore: No. S. E. Cor. Ridgely & Rusk Aves.; Life yrs.. mos. da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Nov 14, 1844 (Month) (Day) (Year)

7-AGE. 77 yrs. 0 mos. 12 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Andrew Koerner

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Susanna Thasher

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George P. Koerner

(Address) S.E. Cor. Ridgely & Rusk Ave

15- NOV 28 1921 Registrar.

Filed NOV 28 1921 191.... Burial Permit Issued.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1921, to Nov 26 1921, that I saw h im alive on Nov 26 1921, and that death occurred, on the date stated above, at 6 10 a.m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Uraemia

(Duration) ....yrs. ....mos. 14 da.

(Signed) Fred E. Hoffman M. D.

Nov 27, 1921. (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bolts Cemetery	Nov 28, 1921
20-UNDERTAKER	ADDRESS
A. S. Marshall	353 Fall Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58927

CERTIFICATE OF DEATH.

64 D 58927

REGISTERED NO.

1-PLACE OF DEATH Ashland Ave & 10th St

CITY OF BALTIMORE: (No. Orangeville ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R. Brooks

(a) RESIDENCE. No. Ashland ave. & 10th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Emory Brooks

6 DATE OF BIRTH (month, day, and year): Feb 8, 1847

7 AGE: Years 74 Months 9 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: at home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Chas. H. Melcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary A. Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mrs. J. L. Mason

(Address): Ashland & 10th st

15 Filed NOV 28 1921 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1919, to Nov 24, 1921, that I last saw h[illegible] alive on Nov 1, 1921, and that death occurred, on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Contracted Last Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2 yrs ago

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Brain abscess

(Signed) E. W. Lamb, M. D.

, 19 (Address) 2502 Bank st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Nov 29 1921

20 UNDERTAKER: Fiekler & Fiekler

ADDRESS 1134 Eager

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 58928 1000 Bks.

D 58928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58928

64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 Augusta ave St. 20 WARD)

2-FULL NAME Charles E. Jendrek

(a) RESIDENCE. NO. 124 Augusta ave St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of Catherine Jendrek

6 DATE OF BIRTH (month, day, and year) May 26 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eugene Jendrek
(Address) 124 Anghsta ave

15 Filed NOV 28 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to Nov 26, 1921, that I last saw h[illegible] alive on Nov 26, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Cvbl

(duration) yrs. mos. 1/2 hr.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Howard Jones, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Nov. 28 1921
20 UNDERTAKER	ADDRESS
F. A. Kenney & Son	703 Kenmore

N. B.—WRITE PLAINLY. WHAT CAUSES DEATH should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58929

CERTIFICATE OF DEATH.

105

D 58929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Michael Brougham

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? South yrs. Mount mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious (Priest)

(b) General nature of industry, business, or establishment in which employed (or employer) Church Work - 019

(c) Name of employer

9 BIRTHPLACE (city or town) Not Known (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Brougham

11 BIRTHPLACE OF FATHER (city or town) Dublin (State or country) Ireland -

12 MAIDEN NAME OF MOTHER Elizabeth Bolton

13 BIRTHPLACE OF MOTHER (city or town) Wexford (State or country) Ireland

14 Informant Records of Mt Stone Retreat

(Address) Mt Stone Retreat

15 NOV 28 1921

ROBERT J. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22nd, 1916, to Nov 26th, 1921, that I last saw him alive on Nov 25th, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

abt (duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Chr Melancholia

abt (duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Nov 26, 1921 (Address) Mt Stone Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cath dral Cemtry — DATE OF BURIAL: Nov 28 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 106 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH INK. ALL ANSWERS, INCLUDING NAMES, SHOULD BE STATED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58930

CERTIFICATE OF DEATH.

1 91

D 58930

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 N. Gay ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonino Geppi

(Residence in Baltimore: No. 444 N. Gay St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 15 (Day), 1921 (Year)

7-AGE, ...yrs. 3 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph Geppi

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Rosa Papa

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Geppi

(Address) 444 N Gay St.

15-

NOV 28 1921

Filed ..... 191.....

BURIAL PERMIT ISSUED

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1921, to Nov 27 1921, that I saw him alive on Nov 27 1921, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Luigi D DiStefano M. D.

Nov 28, 1921 (Address) 407 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem

DATE OF BURIAL, Nov 28, 1921

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58931

CERTIFICATE OF DEATH.

D 58931

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 N Stockton ST.: 18 WARD)

2-FULL NAME Albert Hebron

(a) RESIDENCE. No. 4 N Stockton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colo

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1882

7 AGE: Years 39 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Jobbing
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Levy Hebron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Emma Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis Md

14 Informant: John Thomas Hebron
(Address) 1213 Room St

15 Filed NOV 28 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 1921, to Nov. 26 1921, that I last saw h alive on Nov 25 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Pulm Adenitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Auburn Cem — DATE OF BURIAL: Nov 29 1921

20 UNDERTAKER: A Jones — ADDRESS: 2072 Druid

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58932

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2 E Virginia Ave St. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Julia Jones

(a) RESIDENCE. No. 2 E. Virginia Ave St., formerly live in West End WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? 70 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Jones.

6 DATE OF BIRTH (month, day, and year) July 4 - 1838

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	83	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER James Handly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant Mrs Gallagher (Address) 2 E. Virginia Ave

15 Filed . 19 Registrar

NOV 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1920, to Nov 27, 1921, that I last saw h er alive on Nov. 26, 1921, and that death occurred, on the date stated above, at 9 15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) 2 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George L. Shannon, M. D.

11/27, 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL — DATE OF BURIAL

Washington D.C Nov 29 1921

20 UNDERTAKER — ADDRESS

S. N. Ekler 1944 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58933

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St. Paul + 32nd Sts. Boulevard Apts ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen L. Cumming

(a) RESIDENCE. NO. St. Paul + 32nd Sts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edmund F. Cumming

6 DATE OF BIRTH (month, day, and year): June 10 – 1873

7 AGE: Years 48; Months 5; Days 16; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Hampshire

PARENTS

10 NAME OF FATHER: Thos. J. Sanford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Halifax

14 Informant: Miss Sanford (Address) St Paul + 32nd Sts

15 Filed NOV 28 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 26" 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 . 1921 . to Nov 25 . 1921 . that I last saw h[illegible] alive on Nov 25 . 1921 . and that death occurred, on the date stated above, at 1 00 a m.

The CAUSE OF DEATH* was as follows: Cerebral Arteriosclerosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Appendicitis, by Operation about 13 yrs ago (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

(Address) 1005 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 11/29 1921

20 UNDERTAKER: Chas. F. Evans + Son

ADDRESS: 1180 Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Shock due to the death of Husband no other history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 58934

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby - Bach

(a) RESIDENCE. No. 832 Franklin Road ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-26-21

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Phillip L. Bach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Minnie Talbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: JOHNS HOPKINS HOSPITAL
(Address)

15 Filed . 19 [illegible] Registrar

NOV 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-26, 1921, to 11-27, 1921, that I last saw h[illegible] alive on 11-27, 1921, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Size - 1 lb. 14 oz.

(Signed) Horace G Stewart, M. D.

11/27, 19[illegible] (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 28 1921
20 UNDERTAKER	ADDRESS
Josiah Ryan	1600 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58935

D 58935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Municipal Hospital

CITY OF BALTIMORE (No ..... St.: 2 Ward)

2-FULL NAME Valentine Grosskopf

(a) RESIDENCE. No. 204 S. Chester St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ? 11-27-21

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Hosp. Record
(Address)

15 Filed NOV 28 1921 J. H. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-1921

17 I HEREBY CERTIFY, That I attended deceased from 11-7—, 1921, to 11-27—, 1921, that I last saw him alive on 11-27—, 1921, and that death occurred, on the date stated above, at 7:30 AM m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Clyde McNeil, M. D.

(Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co	11-30 1921

20 UNDERTAKER E. & B. Harle ADDRESS 115 E. West St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58936

CERTIFICATE OF DEATH.

1921 D 58936

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. Franklin Square Hospital 24 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Ruehling Jr

(Residence in Baltimore: No. 1222 Riverside Ave St.; 1 yrs., 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	single

6-DATE OF BIRTH, Oct 6, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Ruehling Sr

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alice Walters

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address).....

15-

Filed....., 191..... Registrar.

NOV 28 1921 S Ellerton

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1921, to Nov 25 1921, that I saw h[illegible] alive on Nov 25 1921, and that death occurred, on the date stated above, at 7:02 P m.

The CAUSE OF DEATH* was as follows:

Empyema of the Chest

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration).....yrs.....mos.....ds.

(Signed) H. C. Warfield M. D.

Nov 25, 1921. (Address) Franklin Square Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn.	11-28, 1921
20-UNDERTAKER	ADDRESS
E. & B. Hasle	116 E. West St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58937

CERTIFICATE OF DEATH.

D 58937

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 E. Biddle ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Zellers

(a) RESIDENCE NO. 1411 E. Biddle ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., if of foreign birth? fifty yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced (HUSBAND) of (or) WIFE of John Zellers

6 DATE OF BIRTH (month, day, and year) Nov 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Peter C. Neher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mr. John Zellers

(Address) 1411 E. Biddle St.

15 Filed NOV 28 1921 ROBERT I. KRAUTZ Registrar

Date to be filled in by Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 25th, 1921, to Nov 27, 1921, that I last saw h[illegible] alive on Nov 26th, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis Duration

Chronic Definite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. mos 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Blum, M. D.

Nov 27th, 1921 (Address) 1301 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 30 1921
20 UNDERTAKER	ADDRESS
Henry Hoecke & Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

58938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard + Green ST.: 4 WARD) X 50

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kelley.

(a) RESIDENCE. No. Lutherville, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH UNFADING INK—THE PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER — unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mr. Ebert
(Address) Lutherville Md.

15 Filed NOV 28 1921 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-24 1921, to 11-25 1921,
that I last saw h/M alive on 11-25 1921
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:

Hemiplegia (left).
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes
(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? Not as yet.
What test confirmed diagnosis? Exam. + Lab.
(Signed) F. A. Holden. M. D.
, 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 29 1921
20 UNDERTAKER	ADDRESS 114 E.
Brown & Lockard	Schroeder

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53939

1-PLACE OF DEATH D 58939 REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Alston

(a) RESIDENCE. No. 1612 McElderry st. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Gilford Alston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records
(Address) M.T.H.

15 NOV 28 1921 Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1921, to Nov. 25, 1921, that I last saw him alive on Nov. 25, 1921, and that death occurred, on the date stated above, at 8.05 a. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L Dadaglass M. D.

11-25-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be careful in the statements they make. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

121

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 58940

D 58940 CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (St.) (Ward)

2-FULL NAME John Moroney

(a) RESIDENCE. No. Falls Road (St.) Bay View Hospital. (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Moroney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Apolonia Reshire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Hospital Record Bay View Hospital

15 NOV 28 1921 BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26 1921

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1921, to November 26, 1921, that I last saw h(im) alive on November 26th, 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 15 minutes. yrs. mos. ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. L. Steadley, M. D.

, 19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 2 1921 19
20 UNDERTAKER Commissioner Health. Per. Wm. E. WOODALL.	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. 47

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58941

CERTIFICATE OF DEATH.

D 58941

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 21 E. Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Hoban

(a) RESIDENCE. No. 21 E. Schroeder ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): married

6a If married, widowed, or divorced (or) WIFE of: Ernest Hoban

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Isiah L. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Emma Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ernest Hoban
(Address) 439 N. Carlisle St

15 Filed NOV 28 1921 19 [illegible] Registrar
Burial Permit [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1921, to Nov. 27, 1921, that I last saw her alive on Nov. 26, 1921, and that death occurred, on the date stated above, at 7.25 p. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

PTBV

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. C. Robinson M. D.

11-28-1921 (Address) 520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov. 29 1921
20 UNDERTAKER	ADDRESS
J. L. Brum & Son	10 W. Mulberry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No lues No tuberculosis
No further history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58942

CERTIFICATE OF DEATH.

104 D 58942

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 W Preston St. Ward)

2-FULL NAME Infant Costen

(a) RESIDENCE. No. 117 W Preston St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/27/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Costen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Blanche Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Geo. Costen

(Address) 117 W Preston St

15 NOV 28 1921 [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26/1921

17

I HEREBY CERTIFY, That I attended deceased from 11/23/1921, to 11/26/1921,

that I last saw h[illegible] alive on 11/26/1921,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

acute gastritis Over

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Errors in diet

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Gunby Morley, M. D.

11/28/1921 (Address) 908 Doham St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Nov 28 1921

20 UNDERTAKER J. L. Bromwell Son — ADDRESS 108 W. Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro intestinal
indigestion.

Spec.—1-10-21—M&T—1500 Bks.

D 58943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58943

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homewood Hospital ST., 12 WARD)

2-FULL NAME Mary Roland Smith

(a) RESIDENCE NO. 319 Dolchester Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6 If married, widowed, or divorced (or) WIFE of Sidney E. Smith

6 DATE OF BIRTH (month, day, and year) Aug 17-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Martinsburg W. Va.
(State or country)

PARENTS

10 NAME OF FATHER Abraham Lynne

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mary D. Smith
(Address) 319 Dolchester Ave

15 Robert F. Harrison,
Filed ..., 19 ..... Registrar
NOV 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 ....., 1921 ....., to Nov 25 , 1921 ,
that I last saw her alive on Nov 25 4:30 P.M. ,
and that death occurred, on the date stated above, at 6:47 P.M.
The CAUSE OF DEATH* was as follows: OVER

Myocardial Insufficiency

(duration) yrs mos 4 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart & Stomach

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 22 1921

Was there an autopsy? No Physical examination

What test confirmed diagnosis?

(Signed) A. H. Stansbury, M. D.

Nov 28 1921 (Address) 714 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL Nov 29 21

20 UNDERTAKER William Cole ADDRESS 50 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hysterectomy performed for beginning cancer of uterus

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58944

CERTIFICATE OF DEATH.

18 D 58944

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Adler.

(a) RESIDENCE. NO. 2240 Brookfield Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Adler

6 DATE OF BIRTH (month, day, and year) Sept. 23 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~Sep~~	46	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer) Employer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sof Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Currie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balt st

15 Filed . 19 Robert P. Harrison, Registrar

NOV 28 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Nov 26, 1921, that I last saw h. im alive on Nov 26, 1921, and that death occurred, on the date stated above, at 9:10 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyemia

(duration) yrs. 3 mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 17 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? Xray + findings at Operation.

(Signed) Edward N Hanrahan Jr, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	11/29 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 58945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58945

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2531 Shirley Ave 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edwin Trumfield

(a) RESIDENCE No. 2531 Shirley Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarissa B Trumfield

6 DATE OF BIRTH (month, day, and year): Nov 10 1835

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
86	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 0/6

(b) General nature of industry, business, or establishment in which employed (or employer): Builder

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Long Town, Balto Co. Md

PARENTS

10 NAME OF FATHER: Caleb Trumfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Long Town Balto Co

12 MAIDEN NAME OF MOTHER: Ann Dellworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bush Creek Md

14 Informant: Mrs Pearlman

(Address) 2431 Guilford

15 Filed . 19

Registrar

Robert P. Harrison,

Burial Permit Clerk

NOV 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1919, to Nov 27, 1921.

that I last saw him alive on Nov 26, 1921

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis and valvular heart disease (aortic)

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Advanced age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinically + Physically

(Signed) Chas J Allen, M. D.

, 19 (Address) 722 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Nov 28 1921

20 UNDERTAKER: H Thompson — ADDRESS: North Avenue

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58946

CERTIFICATE OF DEATH.

X 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child Hosp. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Sier

(a) RESIDENCE. NO..... N & C Hosp. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 23d 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Frederick, Md.

PARENTS

10 NAME OF FATHER Harry Nutz?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Carmine E. Sier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Miss George Hullan
(Address) Nursery and Child's Hospital

15 Filed ..... 19 ..... Registrar
Robert F. Harris?,
Burial Permit Clerk.

V 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1921, to Nov 27, 1921, that I last saw her alive on Nov 27th, 1921, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Chr. Intestinal Intoxication

(duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Emil J Faugler, M. D.

, 19 (Address) 1002 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 29 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 Fayette W

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58947

CERTIFICATE OF DEATH.

152 D 58947

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 W Pratt St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Rutledge

(a) RESIDENCE. No. 860 W Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/21/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Rutledge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Myrtle Marks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Albert Rutledge (Address) 860 W Pratt St

15 Filed Nov 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27/21

17 I HEREBY CERTIFY, That I attended deceased from 11/21, 19 21, to 11/27, 19 21, that I last saw h— alive on 11/25/21, 19 , and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Song, M. D.

Nov 27, 1921 (Address) 710 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westera	11-29 1921
20 UNDERTAKER	ADDRESS 514 N Schroeder St
H. C. Brauneis & Sons	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58948

CERTIFICATE OF DEATH.

64 D 58948

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 233 N. Dunham ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Moore

1a) RESIDENCE. No. 233 N. Dunham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Moore

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 63 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 170

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: St. Mary's Co. Md.

PARENTS

9 BIRTHPLACE (city or town) (State or country): unknown

10 NAME OF FATHER: —

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Lucy Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Mary's Co. Md

14 Informant: Lucy Moore

(Address) 226 N. Dunham St.

15 Filed NOV 29 1921 19 ROBERT J. KEATLEY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1921, to Nov. 27, 1921, that I last saw her alive on Nov. 27, 1921, and that death occurred, on the date stated above, at 12:10 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary) Acute pancreatitis (duration) yrs. mos. 7 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? 1 E Eden & Caroline Sts

Did an operation precede death? no (Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm C Robinson M. D.

11/28 1921 (Address) 520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury, Cem. DATE OF BURIAL: Nov 29 1921

20 UNDERTAKER: Jas. M. Stimas ADDRESS: 1625 E. Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 58949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58949
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 760 W. Lexington ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esperince Stellman

(a) RESIDENCE. No. 760 W Lexington ST. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Horace Stellman

6 DATE OF BIRTH (month, day, and year) Feb 18th 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Nathaniel Stellman

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Elizabeth Zane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Andrew D. Stellman
(Address) 760 W Lexington St.

15 Filed NOV 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1921.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1921, to Nov. 28, 1921, that I last saw her alive on Nov. 27, 1921, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy & Senility

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Consultation.

(Signed) E. F. Dickey M. D.

11-28 1921, (Address) 14 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Tuckahoe N. J. DATE OF BURIAL. Nov 29 1921.

20 UNDERTAKER Mr. & Mrs. John N. Tenfel & Son ADDRESS 801 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58950

CERTIFICATE OF DEATH.

D 58950

1-PLACE OF DEATH

CITY OF BALTIMORE. No. JOHNS HOPKINS HOSPITAL ST.; 7 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lecie Thompson

(a) RESIDENCE. No. 207 9th Ave Altoona Pa ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-9-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —— 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Jack Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Hattie Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed NOV 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-9, 1921, to 11-25, 1921, that I last saw h[illegible] alive on 11-25, 1921, and that death occurred, on the date stated above, at 12 52 a m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

Myocardial Insufficiency

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Landes Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Altoona Pa	Nov 29th 1921
20 UNDERTAKER	ADDRESS
A. Jones	207 S 9th St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58951

CERTIFICATE OF DEATH.

D 58951

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edward L. Clayton (Bertha D)

(a) RESIDENCE. NO. Rock Hall, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Edward L. Clayton

6 DATE OF BIRTH (month, day, and year) July 19 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Lordloff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elise Duering

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E. L. Clayton (Address) Rock Hall Md.

15 Filed NOV 29 1921 . 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1921, to Nov. 27, 1921, that I last saw her alive on Nov. 27, 1921, and that death occurred, on the date stated above, at 3.08 a. m.

The CAUSE OF DEATH* was as follows:

Diverticulates of Sigmoid Colon

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 27, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George E. W. Hartley, M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 29 1921
20 UNDERTAKER John H. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58952

CERTIFICATE OF DEATH.

92

D 58952

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 4 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susana Baldwin

(Residence in Baltimore: No. 641 W. Lexington St ST.; 67 yrs., 8 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: November, 1854
(Month) (Day) (Year)

7-AGE: 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Washington Appleby

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Owens

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nelson T. Baldwin

(Address) 641 W. Lexington St

15-
FILED NOV 29 1921 191
BUREAU OF STATISTICS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Nov. 28th, 1921 (Address) 210 E. Eutaw ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Md. Gen. Hosp. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 641 W. Lexington St.

Former or usual residence same.

19-PLACE OF BURIAL OR REMOVAL, St Mary Hampden — DATE OF BURIAL, Nov. 28 1921

20-UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Mad ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 58953

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Simms (Sims)

(a) RESIDENCE. No. 931 Walnut st. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Sims

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jim Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records (Address) M.T.H.

15 NOV 29 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1921, to Nov. 27, 1921, that I last saw her alive on Nov. 27, 1921, and that death occurred, on the date stated above, at 10.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Francis L Dadaglisacco M. D.

11-28-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 30 1921
20 UNDERTAKER	ADDRESS 142 Wilkes St
John H. Toadvine	

N. B.—WHERE PLANES WITH UNLIKE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58954

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) 4 X 1 ✓ (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Richard Harrison Scanlon

(a) RESIDENCE. No. 905 S. Sharrow St. (St.) Point (Ward.)
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Florence Scanlon

6 DATE OF BIRTH (month, day, and year) July 2 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. Gov't

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER David Scanlon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Delia Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Supt Mercy Hospt
(Address)

15 NOV 29 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1921, to Nov. 28, 1921, that I last saw h.. alive on Nov 28, 1921, and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Internal Perforation

Peritonitis Sepsis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 24-22

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings & Clinical manifestations

(Signed) Louis E. Barkley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Mass	29 1921
20 UNDERTAKER	ADDRESS
Ingell Farley	Balt. & Eutaw

N. B.—WRITE PLAINLY, WITH PEN AND INK. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58955

CERTIFICATE OF DEATH.

794

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1646 Norwood Ave. (St.) 8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta L. Pagel

(a) RESIDENCE. NO. 1646 Norwood Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Pagel

6 DATE OF BIRTH (month, day, and year) Oct 7 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Lindemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Seeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Burns

(Address) 1646 Norwood Ave.

15 Filed NOV 29 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1921, to Nov 27, 1921, that I last saw h alive on Nov 26, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. K. Campbell M. D.

Nov 28, 1921 (Address) 1644 Norwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 30 1921
20 UNDERTAKER	ADDRESS
E. Schlosman & Son	Stemmers Run

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 58956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 58956

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4125 Potter Ave. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katharine Nagel

(Residence in Baltimore: No. 4125 Potter Ave. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Apr. 17/1850 (Month/Day), 1 (Year)

7-AGE, 71 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Burk

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Helena Wessel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Kaenig

(Address) 4125 Potter Ave.

15- NOV 29 1921 Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27/21 (Month/Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16/21 191, to Nov. 18/21 191, that I saw her alive on Nov. 18/21 191, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Womb.

(Duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Emily Wieda Clinch M. D.

Nov. 28/21 191... (Address) 933 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park Cem	Nov 1st 1921
20-UNDERTAKER	ADDRESS
E. Schloman & Son	933 Hanover

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 58957

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 O. Donnell ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Ewalt.

(a) RESIDENCE. No. 2914 O. Donnell ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthon Ewalt.

6 DATE OF BIRTH (month, day, and year) Jan 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Litzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER [illegible].

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Anthon Ewalt. (Address) 2914 O. Donnell St.

15 Filed NOV 29 1921 [illegible] Registrar

Special Form Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1921, to Nov 27, 1921, that I last saw her alive on Nov 26, 1921, and that death occurred, on the date stated above, at 10,40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Hemiplegia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) - Previous Cerebral Hemorrhage

(duration) 3 yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J. Handorf, M. D.

, 19 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov. 30 21

20 UNDERTAKER Lilly & Julier ADDRESS 403 S. Hope

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58958 64 D 58958

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Fourth Ave West, Rognel Heights ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Wallis

(a) RESIDENCE. NO. Fourth Ave West, Rognel Heights ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced (write the word)~~: Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Edward Wallis

6 DATE OF BIRTH (month, day, and year): Nov 6th, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	--	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: ---

9 BIRTHPLACE (city or town) (State or country): Northampton Co. Va.

PARENTS

10 NAME OF FATHER: Frank Mapp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: ----- Hatton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant. Roland Wallis
(Address) Rognel Heights

15 NOV 29 1921 ROBERT J. [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-28 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov-7 1921 to Nov. 28. 1921. that I last saw h[illegible] alive on Nov. 28 1921. and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12hrs.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin J Stock, M. D.

Nov 28 21 (Address) 806 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemetery	Nov 30th, 21
20 UNDERTAKER: Bertram H Fox E.	ADDRESS: 1123 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58959

CERTIFICATE OF DEATH.

91-089
D 58959

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1335 N. Fremont Ave (St.) 14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mills

(a) RESIDENCE. No. 1335 N. Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Mills

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer Don't know

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Nicholas Mills

11 BIRTHPLACE OF FATHER (city or town) Oxford (State or country) Talbot Co. Md.

12 MAIDEN NAME OF MOTHER Victoria Norton

13 BIRTHPLACE OF MOTHER (city or town) Woodlawn (State or country) Harford Co. Md.

14 Informant Mr. Jerome F. Mills
(Address) 1515 Fayette ave.

15 Filed NOV 29 1921 ROBERT I. KEATOR Registrar
Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10 1921, to Nov. 27 1921, that I last saw him alive on Nov. 26 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) William A Harris, M. D.

28, 1921 (Address) 1200 Penn. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Nov. 29 1921
20 UNDERTAKER	ADDRESS
Samuel D. Hemsley	1132 Mc

Spec.—1-10-21—M&T—1500 Bks.

D 58960

HEALTH DEPARTMENT—CITY OF BALTIMORE

4 3rd D 58960

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Mt. Royal Ave ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Centaine Towson

(a) RESIDENCE NO. 1214 Mt. Royal Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Centaine

6 DATE OF BIRTH (month, day, and year) Apr 5th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) (at home)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER James F. Towson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C.

12 MAIDEN NAME OF MOTHER Louisa Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ruth Towson

(Address) 1214 Mt. Royal Ave

15 Filed NOV 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1921 to Nov 26 1921

that I last saw h[illegible] alive on Nov 27 1921

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 14 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 1533 Park Ave

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) H B Culverhouse, M. D.

4/28 1922 (Address) 1901 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem[illegible]

DATE OF BURIAL

20 UNDERTAKER W J Tu[illegible]

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

John J. Purcell Jr.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58961

CERTIFICATE OF DEATH.

18 D 58961

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Rear 1228 N. Lafayette Ave. ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Purcell Jr.

(Residence in Baltimore: No. 401 Lloyd Ave.

Sex (yrs., 2 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 31, 1900
(Month) (Day) (Year)

7-AGE. 21 yrs. 6 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Line Man
(b) General nature of industry, business, or establishment in which employed (or employer): C&P

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. James J Purcell

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Minnie C Sheehan

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J Purcell

(Address) 401 Lloyd ave

15- Filed NOV 29 1921, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocution accidental -

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner)

Nov 26, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	Nov 30 1921
20-UNDERTAKER W M Routson	ADDRESS 2238 N Mont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58962

CERTIFICATE OF DEATH.

170 D 58962

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 W Saratoga St ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Wilson

(a) RESIDENCE. NO. 221 W Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: James R Wilson

6 DATE OF BIRTH (month, day, and year): Oct 16, 1848

7 AGE — Years: 73 — Months: 1 — Days: 11 — If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: James Coffee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Virginia Moody

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Mattie Wilson 221 W Saratoga St

15 Filed NOV 29 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-27. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1921, to Nov 27, 1921, that I last saw her alive on Nov 26, 1921, and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis — 021

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Cold.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. H. Goodwin M. D.

(Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Nov 29 1921

20 UNDERTAKER: W Maurice Routson — ADDRESS: 230 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably ~~old~~ chronic condition of kidneys.

Joshua P. Oler.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58963 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58963

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Reisterstown Rd & Millbrook Lane (Ward) 28 1000 Druid Hill Av

2-FULL NAME Joshua Parsons Oler

(a) RESIDENCE. No. Reisterstown Rd & Millbrook Lane WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wht	Widower

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mattie Quick Oler

6 DATE OF BIRTH (month, day, and year) Jan 6th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper 2 M. Dept U.S. 186

(b) General nature of industry, business, or establishment in which employed (or employer) 2 M. Dept U.S.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Charles Oler

11 BIRTHPLACE OF FATHER (city or town) Balto Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Kennedy

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Eva. Stevens
(Address) Pennrose Av.

15 Filed NOV 29 1921 19 ROBERT J. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Apl. 19 , 1921 , to Nov 29th , 1921 , that I last saw h[im] alive on Nov. 29th , 1921 , and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (2nd)
102 Apl. 19th 21
2nd Nov. 24/21

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia & Paralysis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visible

(Signed) E. H. Smith , M. D.

(Address) 1625 W North Av. 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov. 30 1921
20 UNDERTAKER Horace H. Burgee	ADDRESS 363 Fallsd Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Rks.

Dr Hill
Gladisen Av

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58964

CERTIFICATE OF DEATH.

79 D 58964

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 906 N Fremont ST.: 16 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P McDonnell

(a) RESIDENCE. No. 906 N. Fremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia E McDonnell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cementer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patrick McDonnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Clara McDonnell
(Address) 906 N Fremont Av

15 Filed NOV 29 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 25 Thurs Nov 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1921, to Nov 28th, 1921, that I last saw h in alive on Nov 27th, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Gangrene of Left Foot

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Embolus.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Oct 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J T Hill, M. D.

, 19 (Address) 1208 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 30 19
20 UNDERTAKER	ADDRESS
Wm Fahey & Sons	1827 W Pratt St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not diabetic. Not traumatic
Senile gangrene. Probably
had chronic valvular
heart disease.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58965

CERTIFICATE OF DEATH.

X 170 D 58965

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Walbrook Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Mary Smith.

(Residence in Baltimore: No. 3108 Walbrook Ave. St.; 0 yrs., 6 mos. ? ds.)

WRITE PLAINLY, WITH UNFADING INK. PENCIL WILL NOT REPRODUCE ON RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
~~Male~~ Female	White	Married

6-DATE OF BIRTH, March (Month) 4 (Day), 1864 (Year)

7-AGE, 57 yrs. 8 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Harrisburg Pa

PARENTS.

10-NAME OF FATHER, Daniel Eyfsley

11-BIRTHPLACE OF FATHER (State or Country) Harrisburg Pa

12-MAIDEN NAME OF MOTHER Anna M. Hailey

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas E. Smith - (husband)

(Address) 3108 Walbrook Ave

15- C L S

Filed NOV 29 1921, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 25 1921, to November 28 1921, that I saw h[illegible] alive on November 28 1921, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis -
Arterio Sclerosis -

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Howard A. Warner M. D.

Nov. 28, 1921. (Address) 2634 Harrison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death	—	—	—	In the State	—	—	—
Where was disease contracted, if not at place of death?	—	—	—	—	—	—	
Former or usual residence	—	—	—	—	—	—	

19-PLACE OF BURIAL OR REMOVAL, Westminster - Md DATE OF BURIAL, Dec 1 - 1921

20-UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM E. WOOREN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58966 ✓ D 58966

D 58966

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Donnelly Ct. ST., 10 WARD)

2-FULL NAME John W Suter

(a) RESIDENCE No. 907 Donnelly Ct ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER John W Suter

11 BIRTHPLACE OF FATHER (city or town) (State or country) West-Virginia

12 MAIDEN NAME OF MOTHER Rebecka Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West-Virginia

14 Informant Sadie Watts
(Address) 907 Donnelly Ct.

15 NOV 29 1921 19 BUREAU OF VITAL STATISTICS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1921, to Nov. 27, 1921, that I last saw him alive on Nov. 26, 1921 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Asthma + Dropsy +
Bright Disease

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Asthma + Dropsy + Bright Disease (duration) ..... yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. A. W. Kennard M. D.
11-27 1921 (Address) 758 Encor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int- Aurlon Cemetery	Nov 30 1921
20 UNDERTAKER Wm Robert + Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Spec.—8-24-14—M. & T.—2000 Bks.

D 58967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 V D 58967

1-PLACE OF DEATH 922 Linden Ave

REGISTERED NO. C

CITY OF BALTIMORE: (No. 922 St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Rees

(Residence in Baltimore: No. 922 Linden Ave. St.; 34 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-(SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept. 6th (Month) (Day), 1859 (Year)

7-AGE, 62 yrs. 2 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housewife

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Henry Schantz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lena Steidinger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil Rees

(Address) 922 Linden Ave

15- Filed NOV 29 1921 191.... Buria[illegible] Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27 (Month) (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 1 1921, to Nov. 27 1921, that I saw her alive on Nov. 27 1921, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 8 yrs. — mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) H. T. Pelletier M. D.

Nov. 28, 1921. (Address) 829 Hamilton Ter.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Nov. 30th 1921

20-UNDERTAKER P. H. Seewald & Son — ADDRESS 1825 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58968

CERTIFICATE OF DEATH

38 D 58968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 357 Baltimore ave ST.: No WARD) St Helena

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mae Viola Mitchell

(a) RESIDENCE. No. 357 Baltimore ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Page H. Mitchell

6 DATE OF BIRTH (month, day, and year) June 25 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Roanoke

PARENTS

10 NAME OF FATHER Robert S. Sanderson

11 BIRTHPLACE OF FATHER (city or town) Williamson (State or country) W. Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Page H. Mitchell (Address) 357 Baltimore

15 Filed NOV 29 1921 ROBERT I. KRAUTER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1921, to Nov 28, 1921, that I last saw her alive on Nov 28, 1921, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

037

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Salpingitis - Operated Nov 9-1921 (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 9-1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A.W. Reier, M. D.

4/29, 1921 (Address) Dundalk Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roanoke Va. Inc	Nov 29 1921
20 UNDERTAKER	ADDRESS
Robt J Tanner	1 & 2 N Pine

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated, thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had chronic pelvic inflammatory disease, & appendicitis. Salpingitis due to gonococcus infection. This history is from Church Home where patient was operated upon.

Wm E. Flanigan ✓

D 58969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58969

CERTIFICATE OF DEATH.

168001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 Hundred & twenty six Mulberry St. ST. 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm E. Flanigan

(Residence in Baltimore: No. Boston Mass St.: yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Don't Know, 1886
(Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 046

9-BIRTHPLACE, (State or Country), Boston Mass

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Jack Lewis

(Address) 1411 E. Baltimore St.

15- NOV 29 1921

Filed ....., 191... WM. J. KRAUTZ

Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov ..... 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy on~~ inquiry) thereon and from the evidence obtained by said ..... (~~inquest, autopsy~~ or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas
a Fluchos
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Accidental escape of Gas from Heating Radiator
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M.D.
(Coroner)

11-28-, 1921. (Address) 117 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Dixon Mass. DATE OF BURIAL, 11-29-, 1921

20-UNDERTAKER, Jack Lewis ADDRESS 1411 E. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58970

CERTIFICATE OF DEATH.

X 164 D 58970

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Nursery & Child's Hosp 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Dorsey.

(a) RESIDENCE. NO. N. & C. Hosp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 14 - 192

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Coatsville, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Ella Virg. Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant
(Address)

15 Filed NOV 29 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1921, to Nov 21, 1921, that I last saw her alive on Nov 27th, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal intoxication (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acidosis (duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Emil Stangler M. D.

, 19 (Address) 1902 E Fait St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL NOV. 29 1921 19

20 UNDERTAKER Commissioner Health. ADDRESS

per. Wm. E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

423

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58971

1-PLACE OF DEATH D 58971

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

REGISTERED NO. 120 D 58971

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred McClelland

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Alexander McClelland

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed NOV 29 1921, 19 [illegible]
Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 25 1921, to November 25 1921, that I last saw him alive on November 25, 1921, and that death occurred, on the date stated above, at 5:00 A. M.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic parenchymatous. (?)

(duration) 1 yrs. (?) mos. ds.

Fibrinous Pericarditis

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 (?)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

11/25/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
20 UNDERTAKER Commissioner Health.	ADDRESS NOV 23 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

422

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58972

CERTIFICATE OF DEATH.

81

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 E. 22nd St.: 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Prenger

(a) RESIDENCE. No. 717 E. 22nd St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ellen Prenger

6 DATE OF BIRTH (month, day, and year) April 1, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ex P. D. Capt
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Prenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Rohe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Prenger (Address) 717 E. 22nd St.

15 Filed NOV 29 1921 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/14, 1921, to 11-20, 1921, that I last saw h[er] alive on 11-20, 1921, and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Wolff, M. D.

11/29, 1921 (Address) 914 E Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Nov. 30 1921

20 UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58973 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58973

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 N. Mount ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertina Elizabeth Pursey

(a) RESIDENCE. NO. 1145 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-1-20

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1145 Baltimore Md.

PARENTS

10 NAME OF FATHER Benjamin F. Pursey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Susan R. Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Benjamin F. Pursey Father
(Address) 1145 N. Mount St

15 Filed 19 Robert P. Harrison, Registrar
Burial Permit Clerk

W 29 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1921, to 11-25, 1921, that I last saw h[illegible] alive on 11-27, 1921, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

OVER

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George C. Page M. D.

19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Cemetery	Nov. 29 19 21
20 UNDERTAKER [illegible]	ADDRESS [illegible]

U. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No ileocolitis. No gastro intestinal trouble Quarantine due to improper food.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58974

CERTIFICATE OF DEATH.

53 D 58974

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 E. Fayette St ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kopel Berlin

(a) RESIDENCE NO. 1218 E. Fayette St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Berlin

6 DATE OF BIRTH (month, day, and year) 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	86	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardware

(b) General nature of industry, business, or establishment in which employed (or employer) no work for 20 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Berlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Berlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis (Address) 1411 E Balt St

15 Filed ....., 19 ..... Registrar

NOV 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1921, to Nov 29, 1921, that I last saw him alive on Nov 26, 1921, and that death occurred, on the date stated above, at 11.59 m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukaemia (duration unknown) with chronic nephritis hematuria purpura

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ? ~~yrs.~~ 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood picture

(Signed) Frank J. Lewis, M. D.

, 19 (Address) 924 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	11/30 1921
20 UNDERTAKER	ADDRESS
Jack Levis	1411 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58975

CERTIFICATE OF DEATH.

64 D 58975

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1023 Vine ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Brose

(a) RESIDENCE. No. 1023 Vine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col'd

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont know 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 64

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Burnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Francis Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harry Brose
(Address): 1020 Vine St

15 Filed NOV 29 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1921, to Nov 28, 1921, that I last saw her alive on Nov 27, 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hemiplegia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Pulm Oedema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Woodward M. D.

Nov 29, 1921 (Address) 439 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 30 1921
20 UNDERTAKER	ADDRESS
Brown & Buckland	1140 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

K

D 58976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 58976

REGISTERED NO. C.....

1-PLACE OF DEATH 6th St

CITY OF BALTIMORE: (No. Fairfield ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruffin Taylor

(Residence in Baltimore: No. Fairfield

84 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1861 (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Tenn.

PARENTS.

10-NAME OF FATHER, Miles Taylor

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Taylor

(Address) Fairfield

15- NOV 30 1921 Filed ..... 191.... ROBERT J. BRUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov-14-1921, to Nov-28 1921, that I saw him alive on Nov-25 1921, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

.....

.....

..... (Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

..... (Duration) yrs. 3 mos. ds.

(Signed) W. T. Coleman M. D.

Nov 29, 1921 (Address) 2038 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Nov 30, 1921

20-UNDERTAKER J. H. Bruns' Son

ADDRESS W. Mulberry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dobres

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58977

CERTIFICATE OF DEATH.

153 D 58977

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1812 E. Fayette St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Dobres.

(Residence in Baltimore: No. 1812 E. Fayette, St.; yrs., mos. da.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1874 (Year)

7-AGE, 47 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Polevotick

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mollie Posner

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abraham Dobres

(Address) 812 E. Fayette

15-

Filed NOV 30 1921, 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Carbolic Acid

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) H. K. Whitney M. D.
(Coroner.)

Nov. 29, 1921. (Address) 9 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run

DATE OF BURIAL, Nov 30, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E. Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 58978

D 58978

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Armand Chasteau

(a) RESIDENCE. No. 222 Fremont St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60—70 (?) (apparent)			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed NOV 3 01921 [illegible] Registrar

Burial (or removal) Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1921

17

I HEREBY CERTIFY, That I attended deceased from November 26, 1921, to November 28, 1921, that I last saw him alive on November 27, 1921, and that death occurred, on the date stated above, at 6:10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

11/28/1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross (a a Co)	Nov 30 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58979

CERTIFICATE OF DEATH.

168 D 58979

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1011 E. Fayette St., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Annie Matthews

(Residence in Baltimore: No. 1011 E. Fayette St.; yrs. Lifetimes mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, ... Unknown (Month) ....., 1847 (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Norwich

(Address) 1204 St. Matthew St.

15- Filed NOV 3 01921, 191.. HOWARD J. KRAUTER Registrar

Basic Form

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas poisoning

~~Part~~ Accidental

(Gas tube came off stove NT

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leudley M. D.
(Coroner.)

Nov 30, 1921. (Address) 1659 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, 11/30, 1921

20-UNDERTAKER Chas. J. Evans & Son ADDRESS 1180 Mt. Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 58980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58980

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 96 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Hales

(a) RESIDENCE. No. Bay View ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Murry Hales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed NOV 30 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1921, to Nov. 28, 1921, that I last saw him alive on Nov. 28, 1921, and that death occurred, on the date stated above, at 1.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) Francis L. Delagliese M. D.

11-28-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 30 1921
20 UNDERTAKER	ADDRESS
Henry Lutz	203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

David O'Keefe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58981

CERTIFICATE OF DEATH.

64 D 58981

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Little Sisters of Poor St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME David Okeefe

(Residence in Baltimore: No. Little Sisters of Poor St.; 45 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 69 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Gen'l
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, David O'Keefe

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- NOV 30 1921 Filed ..... 191.. Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 29 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Jowley M. D.
(Coroner)

1-7-22, 191.. (Address) 11 E. Lex St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Cathedral — DATE OF BURIAL. Nov 30, 1921

20-UNDERTAKER H. C. Windfeld — ADDRESS 910 Greenmount Ave

Spec.—1-10-21—M&T—1500 Bks.

Schakowitz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58982

D 58982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Schakowitz

(a) RESIDENCE NO. 2504 E. Balto. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Sam. Schakowitz

11 BIRTHPLACE OF FATHER (city or town) Russia State
(State or country)

12 MAIDEN NAME OF MOTHER Lena Ebram

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Sam Schakowitz
(Address) 2504 E. Balto St

15 Filed NOV 30 1921 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30. 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/27/21, 19 , to Nov. 30, 19 24.

that I last saw him alive on Nov. 30, 19 24

and that death occurred, on the date stated above, at 1630 p. m.

The CAUSE OF DEATH* was as follows:

Acidosis (Enterocolitis)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/30, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave

DATE OF BURIAL Nov. 30 1924

20 UNDERTAKER Mark Levinson

ADDRESS 421 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 58983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 58983

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1364 N. Fremont Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Chas James Roland

(Residence in Baltimore: No. 1364 N. Fremont Ave St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, September, 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Rod Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): 035

9-BIRTHPLACE, (State or Country). Georgia

PARENTS.

10-NAME OF FATHER. James Roland

11-BIRTHPLACE OF FATHER (State or Country). Ga.

12-MAIDEN NAME OF MOTHER. Emma Roland

13-BIRTHPLACE OF MOTHER (State or Country). Ga.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. D. Smith

(Address) 1017 N. Carrollton Ave

15- NOV 3 01921

Filed ..... 191.....

ROBERT A. EIGLER
Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) and Influenza

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Nov. 28, 1921 (Address) 2832 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Sandusky Geo.	Nov. 30. 1921
20-UNDERTAKER	ADDRESS
Barnes & Wright	1364 N. Carey

N. B.—Every item of information should be carefully supplied. AGE should be entered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58984

104 D 58984

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 W. Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robinson

(a) RESIDENCE. NO. 1008 W. Lexington ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: mal

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 20-1921

7 AGE — Years | Months | Days: 5 weeks | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md.

PARENTS

10 NAME OF FATHER: John Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City Md.

12 NAME OF MOTHER: Martha Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John Robinson (Address) 1008 W Lexington St

15 NOV 30 1921 REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1921, to Nov 26, 1921, that I last saw h. alive on Nov 26, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Edema serotum. Probable Acute Nephritis

over

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. P. Clift, M. D.

11/28. 1921 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn | DATE OF BURIAL: Nov 30 1921

20 UNDERTAKER: Daniel Easton | ADDRESS: 916 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had some gastro intestinal trouble. No congenital malformation. No further history

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58985

CERTIFICATE OF DEATH.

D 58985

168

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Biedler & Sellman Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leola Cooke

(a) RESIDENCE. NO. 827 N. Fremont Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 22nd 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boarding House for herself

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) King & Queen Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Monroe Cooke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Emily F. Roane

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Miss Nannie H. Cooke
(Address) 2647 N. Fremont Ave.

15 Filed NOV 30 1921 ROBERT F. FAIRES Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24 1921, to Nov. 29 1921, that I last saw h Ed alive on Nov. 29 1921, and that death occurred, on the date stated above, at 12.30P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis.

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) — yrs. — mos. One ds.

18 Where was disease contracted if not at place of death? 827 N. Fremont Ave

Did an operation precede death? Yes Date of Nov 28/21

Was there an autopsy? No.

What test confirmed diagnosis? Confirmed by operation

(Signed) Herbert F. Eckerman, M. D.

, 19 (Address) 1227 Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Dec 1st 1921

20 UNDERTAKER Joseph L. Cook ADDRESS 1003 N. Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58986

CERTIFICATE OF DEATH.

D 58986

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1819 Edmondson Ave. ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Holmes Perine

(a) RESIDENCE. NO. 1009 W. Baltimore St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. David Perine

6 DATE OF BIRTH (month, day, and year) Aug. 5th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William C. Forney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Pa.

12 MAIDEN NAME OF MOTHER Amelia H. Rochester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant M. David Perine
(Address) 1009 W. Baltimore St.

15 Filed NOV 30 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10. 1921. to Nov 28. 1921.

that I last saw h alive on Nov 21. 1921.

and that death occurred, on the date stated above, at 10.55A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

Nov 28/ 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Nov. 30 1921
UNDERTAKER Joseph B. Cook	ADDRESS 1008 W. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58987

REGISTERED NO. 79 D 58987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 11.3 Highland Ave ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Isabel Miller

(a) RESIDENCE NO. 11.3 Highland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 7-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER J. Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary L. Schuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) J. Henry Miller 11.3 Highland Ave

15 Filed NOV 30 1921 19 J C Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1921

17 I HEREBY CERTIFY, That I attended deceased from October 17th 1921, to Nov 28th 1921, 19 , that I last saw h[illegible] alive on Nov 28th 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) D. H. Hartman, M. D.

11/29/21 (Address) 911 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Dec 1924

20 UNDERTAKER John Herring & Co ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58988

CERTIFICATE OF DEATH.

91 D 58988

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1350 Fremont ST., 15 WARD)

2-FULL NAME Henry Oliver Brown Jr.

(a) RESIDENCE NO. 1350 Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
		5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Oliver Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Fyzie L Sankey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Roucott Va.

14 Informant Fyzie Brown
(Address) 1350 Fremont Ave

15 Filed ..... 19 ..... ROBERT J KRAUTER Registrar

NOV 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27 1921, to Nov 29, 1921, that I last saw him alive on Nov. 29, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)
(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E William Frey, M. D.

Nov 30, 1921 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL Nov 30 1921

20 UNDERTAKER Sam. W. Chase—inc — ADDRESS 1400 Usher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58989

CERTIFICATE OF DEATH.

20 D 58989

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1350 Fremont Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Elmer Brown Sr

(a) RESIDENCE NO. 1350 Fremont Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Brown

6 DATE OF BIRTH (month, day, and year) Dec 5, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	27	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER John Asbury Brown

11 BIRTHPLACE OF FATHER (city or town) Chestertown (State or country) Md.

12 MAIDEN NAME OF MOTHER Sadie Keyes

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant John A Brown (Address) 1350 Fremont Ave

15 Filed NOV 30 1921 19 ~~MOTHER'S~~ REGISTRAR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921 to Nov 27, 1921.

that I last saw h~~e~~r alive on Nov 27, 1921.

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy test

(Signed) William Fuey, M. D.

Nov 29, 1921 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Nov 30, 1921

20 UNDERTAKER Sam'l N. Chase & Son ADDRESS 1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 58990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 58990

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Baynard

(a) RESIDENCE. No. ~~Unknown~~ 517 S Greene St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Date Received NOV 30 1921 Registrar

Burial or Removal

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3 1921 to November 27 1921 that I last saw him alive on November 27 1921 and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Senile Gangrene Right Foot

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Broadrup. M. D.

11/28/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Dec 1 1921
20 UNDERTAKER	ADDRESS
Sam'l H Chase & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not diabetic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58991

CERTIFICATE OF DEATH.

D 58991

37

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 15 WARD)

2-FULL NAME William Perkins

(a) RESIDENCE. No. 1718 Forman ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred: 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary Perkins

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Baltimore, Md.

15 NOV 30 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 19[illegible]

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1921, to Nov. 28, 1921, that I last saw him alive on Nov. 28 6:30 P. m. 19 21, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration ..... yrs. ..... mos. ..... ds.)

CONTRIBUTORY (Secondary) Lues Luetic Infection

(duration ..... yrs. ..... mos. ..... ds.)

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pathological & Serological

(Signed) N. Goldsmith Hinden M. D.

11/29/21 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Laurel — DATE OF BURIAL Dec 1st 1921

20 UNDERTAKER Sam'l H. Chase Son — ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Narciso Koontz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58992

CERTIFICATE OF DEATH.

64 D-58992

1-PLACE OF DEATH

REGISTERED NO. 58992

CITY OF BALTIMORE: (No 904 N. Stricker ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Narcissa Koontz

(a) RESIDENCE No. 904 N. Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15 1835.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER Godfrey Koontz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co. Md.

12 MAIDEN NAME OF MOTHER Mary Jeckle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant R. P. Lupus
(Address) 904 N. Stricker.

15 Filed NOV 3 0 1921 . 19 ROBERT B. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16 , 1921 , to Nov. 28 , 1921 , that I last saw her alive on Nov. 28 , 1921 , and that death occurred, on the date stated above, at 3-30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery Frederick Md	Dec 1 19

20 UNDERTAKER George J Smith — ADDRESS 1000 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58993

CERTIFICATE OF DEATH.

D 58993

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N. Schroder ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Jerkins

(Residence in Baltimore: No. 305 N. Schroder St.; ..... yrs., 4 mos. 7 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb. (Month) 18 (Day), 1896 (Year)

7-AGE, 25 yrs. 9 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): D37

9-BIRTHPLACE, (State or Country). N.C.

PARENTS.

10-NAME OF FATHER, Walter Autry

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Ester Tew

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Autry

(Address) 305 N. Schroder St.

15- ROBERT J. BRUTER

Filed NOV 30 1921 191... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct. 12 1921, to Nov. 29 1921, that I saw her alive on Nov. 28 1921, and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) 2 yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) James M Hayes M. D.

Nov 30 1921 (Address) 513 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence North Carolina

19-PLACE OF BURIAL OR REMOVAL, Goodwood N. Carolina — DATE OF BURIAL, Dec. 1..., 1921

20-UNDERTAKER Brandt & Nelson — ADDRESS 14 W. Lexington St

See affidavit

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58994

D 58994

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Frait ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME archibald Trautfelder

(a) RESIDENCE. No. 2809 Frait ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Trautfelder

6 DATE OF BIRTH (month, day, and year) Dec 27 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~59~~ 55		11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Austin chemical Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Trautfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Dawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. A. K. Clark

(Address) 2809 Frait ave

15 Filed NOV 30 1921 19 ROBERT P. BEAUTEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 25 1921, to Nov 28 1921, that I last saw him alive on Nov 28 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. L. Long, M. D.

11-29-1921 (Address) 2701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Dec 1st 1921

20 UNDERTAKER: Wm C. Miller — ADDRESS 2334 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baltimore, Md., December 15, 1921.

I do hereby make oath that the age given on Baltimore City Department of Health Certificate of Death #58994 as 55 years, 11 months and 29 days should 55 years, 11 months and 29 days. Name of deceased Archibald Trautfelder.

Dr. O. L. Long
Physician.

Subscribed and sworn to before me this 15th day of December, 1921.

Reed Gaither
Notary Public.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Ridgely

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 58995

64 D 58995

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3528 Cottage Ave WARD 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Ridgely

(a) RESIDENCE No. 3528 Cottage Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E Ridgely

6 DATE OF BIRTH (month, day, and year): Feb 17 1841

7 AGE: Years 70 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Artemus Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Matilda Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Annie B Lewis 3528 Cottage Ave

15 Filed NOV 3 01921 ROBERT T. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 22nd, 1921, to Nov 29th, 1921, that I last saw her alive on Nov 28th, 1921, and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) N. R. Leake, M. D.

, 19 (Address) 614 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savage Md — DATE OF BURIAL: Nov 30th 1921

20 UNDERTAKER: William Cook Sons & Hunter — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58996

CERTIFICATE OF DEATH.

64 D 58996

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1710 N Lanvale St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wallace W. Eggleston

(Residence in Baltimore: No. 1710 N Lanvale St.; yrs. 1/2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar 25, 1854
(Month) (Day) (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Electrical Engr
(b) General nature of industry, business, or establishment in which employed (or employer) Comm'n

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jos McEggleston

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Emilie Dennar

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W Eggleston

(Address) 1710 N Lanvale

15- NOV 3 01921 191 ROBERT R KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas E Miller M. D.
(Coroner)

11-28, 1921 (Address) 906 Cath

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Nov 30 1921

20-UNDERTAKER	ADDRESS
Jno F Tennyson & Bro	

Spec.—6-9-19—H. P. Co.—1000 Pks.

D 58997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58997

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Green Spring Ave Melvale ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon C Smith

(a) RESIDENCE. No. Green Spring Ave Melvale ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 or 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 48 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Mr McLanahan

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (address): Gustav M Landgraf Green Spring Ave Melvale

15 NOV 30 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 14th, 1921, to Nov 27th, 1921, that I last saw him alive on Nov 26-27th, 1921, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis

(Aortitis) Angina Pectoris.

(duration) abt 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul. Infarct:

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cause of Disease

(Signed) J. B Hamler Jr. M. D.

. 19 (Address) 24 W Baddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leonard M Eastern

DATE OF BURIAL: Nov 30 1921

20 UNDERTAKER: Samuel F Hamler

ADDRESS: 5 W Baddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. suspicious of lues.

D 58998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58998

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. [illegible] ST. 18 WARD)

2 FULL NAME George L Wadford

(Residence in Baltimore: No. 106 N. Appleton St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Married

6-DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7-AGE: 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lumber
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE. (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Joseph Radford

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Adson

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Radford

(Address) 106 N Appleton

15- ROBERT E KRAUTER

Filed ....., 191.... Burial Permit Issued

NOV 30 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental

Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner)

Nov 30, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Lebanon — DATE OF BURIAL: Nov 30, 1921

20-UNDERTAKER: Samuel T Kennedy — ADDRESS: 5480 Reddle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D 58999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 58999

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2010 E. Monument St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Snyder.

(Residence in Baltimore: No. 1005 Rutland Ave St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Oct. (Month) 18th (Day), 1862 (Year)

7-AGE, 59 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Bailiff
(b) General nature of industry, business, or establishment in which employed (or employer). City

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Wm Snyder

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Fannie Davis

13-BIRTHPLACE OF MOTHER (State or Country). Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Snyder

(Address) 1005 Rutland Ave

15- NOV 30 1921 BOARD OF HEALTH

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner)

12-29-21, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem

DATE OF BURIAL, Dec 1st, 1921

20-UNDERTAKER Geo M. Fruit & Son

ADDRESS 811 N Wolfe St

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59000

CERTIFICATE OF DEATH.

113 D 59000

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 512 N. Schroeder St. (ST.) 18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Kane,

(a) RESIDENCE (No.) 512 N. Schroeder St. WARD. 18
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced (HUSBAND) (or) WIFE of: Cornelius Kane, dec'd

6 DATE OF BIRTH (month, day, and year): Feb 18, 1853

7 AGE: Years 68 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Peter Stalling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Louisa Pierpont

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Mrs Maggie Carter
(Address): 512 N Schroeder

15 Filed NOV 3 01921 19 ROBERT F. KNOTTS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11" 1921 to Nov. 29" 1921 that I last saw h.r alive on Nov 29" 1921 and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): gen. anasarca

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam.

(Signed) Wm Buchanan M. D.

(Address) 1323 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 11-2 1921

20 UNDERTAKER: Henry C Hammond Son

ADDRESS 517 N Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59001

D 59001

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Carroll

(a) RESIDENCE. No. 151 N. Gay St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Richard Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Liza Fithern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed 19 Robert P. Harrison, Registrar

NOV 3 01921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1921

17

I HEREBY CERTIFY, That I attended deceased from July 29 1921, to November 27, 1921, that I last saw him alive on November 27, 1921, and that death occurred, on the date stated above, at 6:35 A. M. The CAUSE OF DEATH* was as follows:

Carcinoma of Face

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. E. Broadrup, M. D.

11/28/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Nov. 30 1921
20 UNDERTAKER	ADDRESS
Stephen J. Kulkowski	1008 S. Kenwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59002

CERTIFICATE OF DEATH.

D 59002

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3176 Fremont ST.: WARD 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie F. Wormuth

(a) RESIDENCE. NO. 3176 Fremont ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. four days mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo Wormuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Rose Lauber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Geo Wormuth
(Address) 3176 Fremont

15 Filed NOV 3 01921 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 25 , 19 21 to Nov 29 , 19 21 ,
that I last saw h alive on Nov 29 , 19 21 ,
and that death occurred, on the date stated above, at 11.15 P m.
The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

, 19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 1921
20 UNDERTAKER	ADDRESS
C. A. Weidefeld Jr	501 E 22

MARGIN MUST BE KEPT CLEAR FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59003

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59003

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3129 Dillon ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Frochlich

(a) RESIDENCE. No. 3129 Dillon ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles G. Frochlich

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. Ompedta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Charles G. Frochlich
(Address) 3129 Dillon St

15 Filed NOV 30 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1921, to Nov 30, 1921, that I last saw h alive on Nov 29, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (Coma)
(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — no.

What test confirmed diagnosis? ~~not~~ clinical

(Signed) ~~not~~ McAvoy, M. D.

Nov 30, 1921 (Address) 8 E 9 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec. 3 1921
20 UNDERTAKER Zickler & Zickler. Per Geo.	ADDRESS 1739 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOV 30 1921

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 59004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Pettis

(a) RESIDENCE. No. Unknown St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joshua Pettis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER May Ardis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records, Municipal Hospital

15 Filed NOV 30 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from August 5, 19 21, to November 27, 19 21, that I last saw him alive on November 27, 19 21 and that death occurred, on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:

Lupus Vulgaris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/28/21 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS NOV 30 1921

Commissioner Health.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic pulmonary tuberculosis

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59005

CERTIFICATE OF DEATH.

64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 400 E. 20th St.: 12 (Ward)

2-FULL NAME Stephen D. Hurley.

(a) RESIDENCE. (No.) 400 E. 20th St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~ or ~~Divorced~~, Widowed. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hurley

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Daniel M. Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs E. Curriers (Address) 400 E. 20th St

15 Filed NOV 3 01921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Nov 30, 1921, that I last saw him alive on Nov. 30, 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A Eichenlaub M. D.

, 19 (Address) 1412 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchendon Mass	Nov 30 1921
20 UNDERTAKER	ADDRESS
Geo Leinbach & Son	647 W Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

D 59006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59006

CERTIFICATE OF DEATH.

X 10-91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hospital St.; 24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Johnson (Fesas)

(Residence in Baltimore: No. 631 S 13th St. Highlandtown St.; ..... yrs., 1 mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W. C.	single

6-DATE OF BIRTH, June 4, 1901
(Month) (Day) (Year)

7-AGE, 20 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Sparrow Pt Steel Co

9-BIRTHPLACE, (State or Country), Greece

PARENTS.

10-NAME OF FATHER, John Fesas

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lavendis

(Address) 631 S. 13 Highlandtown

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 3 01921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 17 1921, to November 28 1921, that I saw h[e] alive on Nov. 28 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) James H. Wilkinson M. D.

Nov 28, 1921. (Address) South Balto Gen Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. 1 mos. ..... ds.

Where was disease contracted, if not at place of death? Balto Md

Former or usual residence McKeesport Pa

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Nov 1, 1921

20-UNDERTAKER John F Denny

ADDRESS 715 Light

Spec.—1-10-21 M&T 1500 Bks.

(Annico) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59007

D 59007

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Low St. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore D'annico

(a) RESIDENCE NO. 1120 Low St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Carmela Catalano

6 DATE OF BIRTH (month, day, and year) Feb. 6-1885

7 AGE 36 Years 9 Months 21 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer. 020

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Gaspare D'annico

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Anna Bruno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Thomas D'annico
(Address) 1503 E. Chase St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

NOV 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1921, to Nov. 28, 1921, that I last saw him alive on Nov. 28, 1921, and that death occurred, on the date stated above, at 12.15A m.

The CAUSE OF DEATH* was as follows: Over

Aneurysm of Thoracic Aorta (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fluoroscope + X-ray

(Signed) E. L. Ferraro M. D.

Nov 30, 1921 (Address) 2en Hills Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Geo. J. Ruth — DATE OF BURIAL Dec 1 1921

20 UNDERTAKER Holy Redeemer Cem — ADDRESS 1730 Monroe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59008

CERTIFICATE OF DEATH.

50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1745 St Charles St.: 23 WARD)

2-FULL NAME Daniel Collins

(a) RESIDENCE. NO. 1655 St. Charles ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 645

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware & Paints

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jas Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not Know

12 MAIDEN NAME OF MOTHER Eliz Yake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not Know

14 Informant Daniel Collins Jr (Address) 1655 Charles St

15 Filed Robert P. Harrison, Registrar

NOV 30 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1921, to Nov 28, 1921, that I last saw him alive on Nov 28, 1921, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) L. Hilgartner M. D.

(Address) 1 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	12/2/19
20 UNDERTAKER	ADDRESS
Jas J Fahey & Sons	138 Light St

MARGIN RESERVED FOR BINDING — WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59009

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59009

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1129 Hull St. ST. 24 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Meyer.

(Residence in Baltimore: No. 1129 Hull St. St.; 51 yrs. 10 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: January 20, 1870 (Month) (Day) (Year)

7-AGE: 51 yrs. 10 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laundry Work 041
(b) General nature of industry, business, or establishment in which employed (or employer): Shirt Factory

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Amiel Meyer

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Mary A Meyer

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertrude Gibbons

(Address) 1129 Hull St

15- Robert P. Harrison, ... 191 .....
Burial Permit Clerk. REGISTRAR

NOV 30 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November 29, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 13, 1921, to. November 29, 1921 that I saw h.. alive on November 28, 1921 and that death occurred, on the date stated above, at 8-55 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage 4 Hours

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Mitral Regurgitation

(Duration) ..... yrs. ..... mos. 16 ds.

(Signed) Nesta Stevens M. D.

11/29, 1921 (Address) 2878 Stafford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Cross

DATE OF BURIAL: 12/1, 1921

20-UNDERTAKER: Fahey & Sons

ADDRESS: 318 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59010

Spec. (60) H. D. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robt Garrett Hosp for Children REGISTERED NO. 1047

CITY OF BALTIMORE: (No. 27 N Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sherlock F. Nettleship

(a) RESIDENCE. NO. 1602 N Gilmor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alvin E. Nettleship

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Charlotte L. Lloyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charlotte L. Nettleship
(Address) 1602 N. Gilmor St

15 DEC 1 - 1921 ROBERT P. BRUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1921, to Nov 30, 1921, that I last saw h[illegible] alive on Nov 30, 1921, and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible] Clift, M. D.

"30, 1921 (Address) 27 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Dec 1 1921
20 UNDERTAKER Jno. & Jno L. N. Teufel & Son	ADDRESS 801 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 59011

CERTIFICATE OF DEATH.

D 59011

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 E. Federal ST., 8 WARD)

2-FULL NAME LeRoy Adams

(a) RESIDENCE NO. 2127 Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo E. Adams

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Koellner

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Geo E. Adams
(Address) 2127 E. Federal St

15 Filed DEC 1-1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1921, to Nov 30, 1921, that I last saw him alive on Nov 30, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Cumming, Acute Paren-Chymatous Nephritis & Tonsilectomy

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Diphtheria & Nephritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Clinical

(Signed) D. B. Carman, M. D.

11-30 1921 (Address) 1701 E Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 1 1921

20 UNDERTAKER Geo Nosset — ADDRESS 1442 N Gay

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tonsillar Diphtheria

Teresa Coffield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59012

CERTIFICATE OF DEATH.

1 5 V D 59012

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1541 Orleans St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tecara Coffield

(Residence in Baltimore: No. 1541 Orleans. St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col.	Sing.

6-DATE OF BIRTH, Nov 25, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto City Md

PARENTS.

10-NAME OF FATHER. Ivory Coffield

11-BIRTHPLACE OF FATHER (State or Country). Greenville S.C.

12-MAIDEN NAME OF MOTHER Sarah Tatum

13-BIRTHPLACE OF MOTHER (State or Country). near Burt Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ivory Coffield

(Address) 1541 Orleans St

15-

FILED DEC 1 - 1921 19.. [illegible] Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Jury
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edwin Smith M. D.
(Coroner)
11:30, 1921 (Address) 4 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
at Burt cemetery	Dec 1, 1921

20-UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59013

CERTIFICATE OF DEATH.

K 50 D 59013

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) 4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Janet Benson

(a) RESIDENCE. No. Cockeysville Md St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced (H~~USBAND~~) of (or) WIFE of Emary W. Benson

6 DATE OF BIRTH (month, day, and year) 1887-1

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 091

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford Co Md.

PARENTS

10 NAME OF FATHER Walter S. Reckard

11 BIRTHPLACE OF FATHER (city or town) Hartford (State or country) Co Md.

12 MAIDEN NAME OF MOTHER Lillian C. Hemsworth

13 BIRTHPLACE OF MOTHER (city or town) Hartford (State or country) Co. Md

14 Informant Emary W. Benson (Address) Cockeysville Md

15 Filed DEC 1 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-28, 1921, to 11-30, 19..., that I last saw h.. alive on 11-30, 1921, and that death occurred, on the date stated above, at 10 40 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Acidosis

Pregnancy (duration) ... yrs. ... mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Exam.

(Signed) J. A. Holden, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Balto Co DATE OF BURIAL Dec 2-21

20 UNDERTAKER W. C. Brooks ADDRESS Govans Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59014

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59014

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 415 W Hoffman ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh B Watson

(a) RESIDENCE. No. 415 W Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mattie Watson

6 DATE OF BIRTH (month, day, and year) May 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Benjamin Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sophia Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mattie Watson
(Address) 415 W. Hoffman St

15 Filed . 19 ROBERT A. KRAMER Registrar

DEC 1 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 29 . 1921, to Nov 29 . 1921

that I last saw him alive on Nov 29 . 1921,

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral -

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

Not Known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Samuel A Bain, M. D.

. 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. D. Auburn Sem. DATE OF BURIAL: Dec 1 1921

20 UNDERTAKER: Samuel Handley ADDRESS: N Bible

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59015

CERTIFICATE OF DEATH.

19 D 59015

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 300 N. Parish (St.) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Johnson

(a) RESIDENCE. No. 300 N. Parish St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Johnson

6 DATE OF BIRTH (month, day, and year) Feb 5. 1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER James Toomey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Susan Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant (Address) Mary Hawkins 300 N Parish St

15 Filed DEC 1 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1921, to Nov. 28, 1921, that I last saw h alive on Nov 27, 1921, and that death occurred, on the date stated above, at 7-30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical History

(Signed) James Brown, M. D.

11/28 1921 (Address) 183 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 1 1921

20 UNDERTAKER Samuel Hensley

ADDRESS 878 W Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59016

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ehlert

(a) RESIDENCE. No. 1817 Lemon St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER George Ehlert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Date DEC 1-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from November 14, 1921, to November 30, 1921, that I last saw him alive on November 29, 1921, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

11/30/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Dec. 3, 1921
20 UNDERTAKER	ADDRESS
Wm Cook	5026 Nork ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59017

CERTIFICATE OF DEATH.

D 59017

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 39 Belair Road cor. Montana (ST.) Raspeburg (WARD) 27 REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Berger.

(Residence in Baltimore: No.) 39 Belair Rd Cor Montana ave (St.) Raspeburg (Length of residence in city, ward, town, or village) 46 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	W.	Married

6-DATE OF BIRTH, Dec. (Month) 15 (Day), 1876 (Year)

7-AGE, 44 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Jasper

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Berger

(Address) 39 Belair Road Raspeburg

15- Filed DEC 1 - 1921 ROBERT J. BRAUER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28th 1921, to Nov 29th 1921, that I saw h[illegible] alive on Nov 29th 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 24 hrs. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Gustave A. Pfeyl M. D.

11-29, 1921 (Address) Aberdeen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Jerusalem Cemetery	Dec 2, 1921
20-UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59018

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 W. Fayette St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Wells

(a) RESIDENCE. No. 733 W. Fayette St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo. H. Wells

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bridie Challacer
(Address) 315 N. Paca St

15 Filed DEC 1 - 1921 19 ROBERT J. BRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1921, to Nov 30, 1921, that I last saw h[illegible] alive on Nov 30, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

12-1, 1921 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	Dec 1st 1921
20 UNDERTAKER	ADDRESS
Geo M. Frick & Son	811 N Wolfe

Spes.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59019

CERTIFICATE OF DEATH.

56 D 59019

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 912 Columbia ave ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Manion

(a) RESIDENCE No. 912 Columbia ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Streetman 079

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Worker

(c) Name of employer Am Bridge Co Rem Belto

9 BIRTHPLACE (city or town) Ind.
(State or country)

PARENTS

10 NAME OF FATHER Michael Manion

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Mullan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Dennis Manion.
(Address) 912 Columbia ave.

15 Filed DEC 1 - 1921 ROBERT A KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 19 21, to Nov 29, 19 21,

that I last saw h alive on Nov 29, 19 21

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism (Cirr.)

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1227 E Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	12-3 1921
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59020

CERTIFICATE OF DEATH.

79 D 59020

1-PLACE OF DEATH Volunteers of Am Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 414 w Lexington ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Newman

(a) RESIDENCE. No. 927 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addline Newman

6 DATE OF BIRTH (month, day, and year) Sept 6, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) P. a.

12 MAIDEN NAME OF MOTHER Louisa Olinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) P. a.

14 Informant L. C. Newman
(Address) 216 E. East Ave

15 Filed DEC 1 - 1921 BOYER'S STAMP Registrar Bureau Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV - 29 1921

17 I HEREBY CERTIFY, That I attended deceased from NOV. 27 —, 1921, to NOV 29, 1921.

that I last saw h[illegible] alive on NOV - 29, 1921,

and that death occurred, on the date stated above, at 3-30 a. m.

The CAUSE OF DEATH* was as follows:

Edema of the Lungs —

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) hypertension - acute dilation (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 927 madison ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms.

(Signed) J. L. Fayerweather M. D.

, 19 (Address) 414 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec. 1. 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59021

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D 59021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Getner

(a) RESIDENCE. No. 212 S. Duncan Alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Getner

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Life Guard

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Getner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

15 Filed ..... 19 DEC 1 - 1921 ROBERT I. KRAETER Registrar
Baptist Powell Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1921, to Nov. 29, 1921, that I last saw him alive on Nov. 29, 1921, and that death occurred, on the date stated above, at 7.28 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis Padaglisco, M. D.

11-30-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Dec. 3 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Eutaw St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59022

CERTIFICATE OF DEATH.

D 59022

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 Boyd St. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Blossom Noyes

(a) RESIDENCE. No. 2033 Boyd St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24th 1913

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Noyes

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lotta Clark

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Christian Zell
(Address) 2033 Boyd St.

15 Filed DEC 1 1921 . 19 [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 28 1921, to Nov 30 1921,

that I last saw h[illegible] alive on Nov 30 19[illegible],

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Diptheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

19 (Signed) Bernard S. Smart, M. D.

12/1, 1921 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 1st 1921

20 UNDERTAKER Joseph B Cook

ADDRESS No 3 N Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59023

1-PLACE OF DEATH: US. Public Health Hosp. #56

CITY OF BALTIMORE: (No.) Fort McHenry Baltimore Md. 24 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Claude J/ Kirby

(a) RESIDENCE NO. US. Public Health Hosp. #56 Baltimore Md. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ----

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	25 yrs.	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ----
(c) Name of employer: ----

9 BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS
10 NAME OF FATHER: unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown
12 MAIDEN NAME OF MOTHER: unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T. Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Balto. Md.

15 Filed DEC 1 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from August 3, 1921 to November 30, 1921 that I last saw h im alive on November 30, 1921 and that death occurred, on the date stated above, at 9'15 A.M.

The CAUSE OF DEATH* was as follows:

Tiberculosis chronic pulmonary far adv. & active

August 3,/21 (duration) -- yrs. -- mos -- ds.

CONTRIBUTORY --- (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical Report.

(Signed) Thomas R. Payne Senior Surgeon (R) M. D.

11/30 1921 (Address) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Albans W. Va — DATE OF BURIAL: Dec, 1921

20 UNDERTAKER: S. Linn & Bro — ADDRESS 112 E. Balto St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59024

D 59024

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1269 Battery Ave ST.; 24th WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E Gilbert

(Residence in Baltimore: No. 1269 Battery Ave St.; 6 yrs. 6 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, 7 (Month) 5 (Day), 1856 (Year)

7-AGE, 65 yrs. 4 mos. 23 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country) Westmoreland Co Va

PARENTS.

10-NAME OF FATHER, Benj English

11-BIRTHPLACE OF FATHER (State or Country), Westmoreland Co Va

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Westmoreland Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Gilbert Husband

(Address) 1269 Battery Ave

15-

Filed DEC 1 - 1921 191 ROBERT J KRAUTER Registrar.

BURIAL PERMIT Cloth.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11.3. 1921, to 11.28 1921, that I saw her alive on 11.28 1921, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Not known (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chron Anemia

(Duration) yrs. 3 mos. da.

(Signed) L.D. Darlington M. D.

11.29, 1921 (Address) 612 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Dec 1 191...

20-UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Eutaw St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Roeth

D 59025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59025

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH 25 ward

CITY OF BALTIMORE: (No. Pine Crest Sanatorium St. Norwood Ave. nr. Frederick Ave. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Roeth

(a) RESIDENCE. NO. 933 W. Fayette St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick A. Roeth

6 DATE OF BIRTH (month, day, and year) Nov. 14" 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	0	16	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland
(State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Pipenbrink

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmine Schmidt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Charles F. Roeth
(Address) Greenspring Park, Md. Baltimore Co.

15 Filed . 19 [illegible] Registrar

DEC 1 - 1921

Burial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30" 19 21

17 I HEREBY CERTIFY, That I attended deceased from September 20, 1921, to Nov. 30" 19 21, that I last saw h[illegible] alive on Nov. 30" 19 21, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Deterioration of Arteries
Asthenia
(duration) yrs. mon. 10 ds.

CONTRIBUTORY (Secondary) Arthritis Deformans
(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Lang, M. D.

. 19 (Address) 933 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Co.	Dec 3" 1921
20 UNDERTAKER Joseph B Cook.	ADDRESS 1003 N. Bal. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59026

CERTIFICATE OF DEATH.

64 D 59026

REGISTERED No. C

:PLACE OF DEATH

CITY OF BALTIMORE (No. 214 Clay St. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Franklin Fiske

(Residence in Baltimore: No. 3631 Liberty Hts ave ST.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June (Month) 2 (Day), 1850 (Year)

7-AGE. 71 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Boston Mass

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER A. S. Hruss Clapp

13-BIRTHPLACE OF MOTHER (State or Country), Boston Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barkley D. Fiske

(Address) 3713 Liberty Hts ave

15-

Filed ....., 191.... Registrar.

DEC 1 - 1921 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy~~ or inquiry) thereon and from the evidence obtained by said (Inquest, ~~autopsy~~ or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) a few hours

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Jamieson M. D. (Coroner)

12-1-1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Dec 2 1921
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59027

CERTIFICATE OF DEATH.

D 59027

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Banks ST.; WARD)

REGISTERED NO. C 119

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen & Epps (Opes)

(Residence in Baltimore: No. 2105 Banks St.; 4 Yrs., 7 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September 17, 1878 (Month) (Day) (Year)

7-AGE, 43 yrs. 2 mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Gray

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Gray

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clifford J. Epps (Opes)

(Address) 2105 Banks

15-

Filed DEC 1 - 1921, 191

Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1921, to Nov 29 1921, that I saw her alive on Nov 29 1921, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Parenchy. Nephritis

(Duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 2 da.

(Signed) Chas. D. Keer M. D.

12/1/21, 191... (Address) H of Chas St & Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Dec 3, 1921

20-UNDERTAKER Windell Oppelt & Son — ADDRESS 370 W Mn

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59028

CERTIFICATE OF DEATH.

150 D 59028

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S Chester St.: 2 Ward)

2-FULL NAME Emma B. Kolb

(a) RESIDENCE. No. 412 S Chester St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 400

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Charles Kolb

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country)

12 MAIDEN NAME OF MOTHER Emma Heilbel

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Charles Kolb
(Address) 412 S Chester St

15 Filed DEC 1 - 1921 Robert P. Garrison, Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1921, to Nov 30, 1921, that I last saw her alive on Nov 29, 1921, and that death occurred, on the date stated above, at 5-20 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(duration) yrs. - mos. ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Whitridge Williams, M. D.

1924 (Address) 1st & Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 2 1921

20 UNDERTAKER Wendell Dippel & Son ADDRESS 378 Am

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59029

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 525 Walnut ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Wren

(a) RESIDENCE. No. 525 Walnut ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Wren

6 DATE OF BIRTH (month, day, and year) Oct 20 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	years	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Petersburg, Va.

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Petersburg, Virginia

12 MAIDEN NAME OF MOTHER Minnie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Petersburg, Virginia

14 Informant Mrs. Maggie Burke (Address) 526 Walnut St

15 Filed Nov 19 Robert P. Harrison, Registrar

DEC 1 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1921, to Nov 29, 1921, that I last saw her alive on Nov 29, 1921, and that death occurred, on the date stated above, at 11:55 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R. Gosey M. D.

, 19 (Address) 753 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec. 2, 1921
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	1114 W. Saratoga St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *Septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not suspicious of lues.

D 59030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59030

151

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1844 Eagle St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby. Haberer

(Residence in Baltimore: No. 1844 Eagle St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)

6-DATE OF BIRTH, Nov 26th, 1921 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or rstablishment in which employed (or employer): —

9-BIRTHPLACE. (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Harry Haberer

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Mary Stewart

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Haberer

(Address) 1844 Eagle st

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

DEC 1 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH* was as follows:

(True) Malformation birth
Inanition

(Duration) ....yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Pylorostenosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Eaton Yeats M. D.
(Coroner)

Nov 30, 1921 (Address) 1436 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Dec 2nd 1921

20-UNDERTAKER A. Jones — ADDRESS 207 E Biddle St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 15 15 23.
D 59031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 59031

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Savoy
?

(a) RESIDENCE. No..... St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
?	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore ? Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER Marie? Savoy

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Local

15 Filed Dec 1 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 22 1921, to Nov. 29, 1921, that I last saw her alive on Nov. 29, 1921, and that death occurred, on the date stated above, at 12 ST A. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus, obstructive
Congenital

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Streptococcus meningitis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hospital

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Cerebro Spinal Fluid
Lumbar puncture.

(Signed) Horace G. Stewart, M. D.

11/29, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	DEC 1 1921
20 UNDERTAKER	ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59032

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: 15 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Schneider

(a) RESIDENCE. No. 802 N. Appleton St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mathew Schneider

6 DATE OF BIRTH (month, day, and year) Nov 5, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	-	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER James McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Beeborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed DEC 1-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29- 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 24 . 1921 . to Nov 29 . 1921 . that I last saw her alive on Nov 29 . 1921 . and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ~~yrs~~ ~~mos~~ 3 ds.

CONTRIBUTORY (Secondary) Carcinoma stomach?

(duration) yrs. 3-4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Ordinary examinations.

(Signed) D B Branham, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Dec 2nd 1921
20 UNDERTAKER E. LeRoy Fletcher	ADDRESS 1252 Park Ave

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59033

CERTIFICATE OF DEATH.

D 59033

X 79-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Boyle's Hospital ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Smith

(a) RESIDENCE. NO. Bymuse , Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Smith

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant John Smith
(Address) Culpeper Virginia

DEC 1 1921 Robert E. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14 1921 to Dec. 1 1921 that I last saw her alive on Dec. 1 1921 and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows: OVW

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 26, 21

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) S W Rowley, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Culpeper Virginia	Dec 2 1921
20 UNDERTAKER Fant Brockdon	ADDRESS Culpeper

be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of CUPA- CAUSE OF DEATH in plain terms, so that it may be of certificates. TION is very important. See instructions on back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for hyperthyroidism
Secondary bronchopneumonia.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59034

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 528 S. Smallwood ST.: 70th WARD)

2-FULL NAME Theodore Hemller

(a) RESIDENCE. No. 528 S. Smallwood ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mns. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Mary Hemller

6 DATE OF BIRTH (month, day, and year): Sept 20-1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fred'k Hemller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Betty Hemller
(Address) 528 S. Smallwood Ave

15 Filed ..... 19 ..... Registrar
Robert P. [illegible]
Burial Permit Clerk.

DEC 1 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 25 1921, to Nov 29 1921, that I last saw him alive on Nov 29 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A. Eiry, M. D.

Dec 1, 1921 (Address) 524 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 1st 19
20 UNDERTAKER	ADDRESS
H B Klippert	2336 Fulton Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59035

D 59035

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Tuxedo Av ST.: 12 WARD)

2-FULL NAME Elizabeth A. Smith

(a) RESIDENCE. No. 421 Tuxedo Av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. H. Smith

6 DATE OF BIRTH (month, day, and year): Dec 27. 1863

7 AGE — Years: 57 — Months: 11 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Geo. Maryland

PARENTS

10 NAME OF FATHER: John Trambleto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Geo. Maryland

12 MAIDEN NAME OF MOTHER: Catherine Key

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Geo Maryland

14 Informant (Address): Geo. H. Smith 421 Tuxedo St.

15 Filed DEC 1 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept X 10, 1921, to Nov 29, 1921, that I last saw h[er] alive on Nov 29, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. few mos. ds.

CONTRIBUTORY (Secondary) Diabetic Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. A. Pechin M. D.

Nov. 30, 1921 (Address) 112 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec. 2 1921

20 UNDERTAKER: Horace H. Burgie — ADDRESS: 363 Fallsd.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 59036

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 N. 39th. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Wheeler

(a) RESIDENCE. No. 2100 N. 39th. ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Wheeler

6 DATE OF BIRTH (month, day, and year) Sept. 25-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Overseer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mill

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Wheeler

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Maryland

12 MAIDEN NAME OF MOTHER Angeline Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Josephine Wheeler (Address) 2100 N. 39th St.

15 Filed Robert P. Harrison, Registrar

DEC 1 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1921, to Nov. 30, 1921, that I last saw h alive on Nov. 30, 1921, and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood exam.

(Signed) W. S. D. Smith, M. D.

. 19 (Address) 8424 Chestnut Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Dec 3 1921

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Fallsrd

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59037

CERTIFICATE OF DEATH.

× 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St.; 17 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8).)

2-FULL NAME Charles F Kellman

(Residence in Baltimore: No. Provident Hospital (Sparks Md St.;) yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... September ..... (Month) ..... (Day) ....., 1869 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Valet
(b) General nature of industry, business, or establishment in which employed (or employer)..... 670

9-BIRTHPLACE, (State or Country), Brooklyn N.Y.

PARENTS.

10-NAME OF FATHER, Thomas Freeman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bessie

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celestial Freeman

(Address) Brooklyn, New York

15-

Filed ..... 191... Robert F. Harrison, Registrar.

DEC 1 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... (Month) – 1 ..... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1921, to Dec - 1 1921, that I saw him alive on Dec - 1 - 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Segundo

Retention of Urine

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) C E Hughes M. D.

Dec 1, 191... (Address) 1403 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Sparks Md

Former or usual residence Brooklyn N.Y.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Brooklyn New York	Dec 6 1921

20-UNDERTAKER	ADDRESS
Samuel T Lemley	5718 Belair

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Chronic nephritis Not tuberculous

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59038 D 59038

CERTIFICATE OF DEATH.

REGISTERED NO. C 87

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2505 Roslyn Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wagner

(Residence in Baltimore: No. 2505 Roslyn Ave St.: 60 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Nov (Month) 10 (Day), 1833 (Year)

7-AGE, 88 yrs. — mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 86
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas W. Schaffer

(Address) 204 N. Calvert St

15- Robert P. Harrison,

Filed DEC 1 1921, 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from — 1910, to Dec 1 1921, that I saw h[im] alive on Nov 19 1921, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Old age. Patient really just wore out from old age in spite of contributing conditions noted below.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Atheroma. Evident 4 years ago. Partial hemiplegia (Duration) 4 yrs. 5 mos. ds.

(Signed) Geo. T. Kemp M. D.

Dec 1, 1921. (Address) St. James Apartments

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cemetery

DATE OF BURIAL, 12/2/1921

20-UNDERTAKER Chas P. Evans & Son

ADDRESS 1810 N. Monroe

4-B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ X 172 D 59039

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Warren Carson

(a) RESIDENCE. No. Richmond ST.: Virginia WARD. Richmond Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 900

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER J. Preston Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Kate Montague

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Records

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

C 1-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1921, to Dec 1, 1921, that I last saw h[illegible] alive on Dec 1, 1921, and that death occurred, on the date stated above, at 8:20 p. m.

The CAUSE OF DEATH* was as follows:

Fracture left femur OWI
pathological (bone cyst)

(duration) yrs. 5 mos. 0 ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Richmond Va

Did an operation precede death? Yes. Date of Dec 1 1921

Was there an autopsy? No.

What test confirmed diagnosis? Path Exam specimen at operation

(Signed) L. K. Gramley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va.	Dec 2 1921
20 UNDERTAKER	ADDRESS
John C. Mitchell	1201 N. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Last July broke bone by diving. No further history. Not tuberculous.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59040

CERTIFICATE OF DEATH.

79-091 D 59040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3007 Garrison Ave ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis G. Walter

(Residence in Baltimore: No. 3007 Garrison Ave. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, January (Month) 9th (Day), 1862 (Year)

7-AGE, 59 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Clothing Merc.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Walter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henriatta Gutz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Kraus

(Address) 316 S. Eutaw St.

15- Filed DEC 2 - 1921, 191... ROBERT J. KRAUSE Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1921, to Nov 30 1921, that I saw h.. alive on Nov 30 1921, and that death occurred, on the date stated above, at 9A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) ....yrs. ....mos. ....ds.

(Signed) Walter L. Kenney M. D.

Nov 30, 1921 (Address) 35[illegible] Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Shalom — DATE OF BURIAL, Dec 2, 1921

20-UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Mad Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 D 59041

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 507 W Lombard St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Bevans

(Residence in Baltimore: No. 507 W Lombard St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Don't Know ....., 1..... (Month) (Day) (Year)

7-AGE: 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Bath Md

PARENTS.

10-NAME OF FATHER: Thos M Bevans

11-BIRTHPLACE OF FATHER (State or Country): Pa

12-MAIDEN NAME OF MOTHER: Mary E. Heel

13-BIRTHPLACE OF MOTHER (State or Country): Fr. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry L Bevans

(Address) Morrisons Pa

15- Filed DEC 2 - 1921 ROBT. J. KRAUSE, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 30, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held na ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... ~~(Inquest, autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Gas - .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch, M. D. (Coroner)

12-2, 1921. (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Stone Chapel — DATE OF BURIAL: 12/2/21

20-UNDERTAKER: H. J. Eichner & Sons — ADDRESS: 240 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59042

CERTIFICATE OF DEATH.

21 D 59042

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1824 N. Caroline ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Ward

(a) RESIDENCE NO. 1824 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 7/10/1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secty 086

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliz Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John J Ward Jr (Address) 1824 N. Caroline St

15 Filed DEC 2 - 1921 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Nov 31 1921, that I last saw h-- alive on Nov 31 1921, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 2 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? can not say

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Spencer Brush M. D.

Dec 2nd 1921 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Dec. 3rd 1921

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY, with unfading ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59043

CERTIFICATE OF DEATH.

91 D 59043

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cambridge Apts ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn H. Seevers.

(a) RESIDENCE. No. Cambridge Apts ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, ~~or Divorced~~ (write the word): Single

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE — Years: 81 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William R. Seevers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Emily Humphreys

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Blackwood Smith
(Address): Berryville Va

15 Filed DEC 2 - 1921, 19 Registrar: J E Wehn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1921, to Nov 30, 1921, that I last saw her alive on Nov 30, 1921, and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Hypostasis (duration) 21 yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) William L Ward, M. D.

19 (Address) Mt Washington

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12-2 1921
20 UNDERTAKER: Stevenson Jenkins & Sons Co	ADDRESS: W Fulton Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Maston Bass Jr.

D 59044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 59044

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5000 Beauregard Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maston Bass Jr.

(a) RESIDENCE. NO. 5000 Beauregard Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 29-1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. 380

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Maston Bass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Isabelle Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Maston Bass
(Address) 5000 Beauregard Ave

15 Filed DEC 2 - 1921 19 ROBERT I. GRAITHS Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30-1921

17 I HEREBY CERTIFY, That I attended deceased from 11-29-, 1921, to 11-30-, 1921, that I last saw h[illegible] alive on 11-30-, 1921, and that death occurred, on the date stated above, at 12,30 P m.

The CAUSE OF DEATH* was as follows:

Contracted Palmer

Over

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.

11-22 1921 (Address) 611 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 2 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital malformation.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 59045

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 E Madison ST.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydnon L Lee

(Residence in Baltimore: No. 1520 E Madison St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. ....., 1..... (Month) (Day) (Year)

7-AGE. 21 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION: 040

(a) Trade, profession, or particular kind of work..... Sailor [redacted]

(b) General nature of industry, business, or establishment in which employed (or employer)..... Labor [redacted]

9-BIRTHPLACE. (State or Country) live in Balt-4 years Virginia

PARENTS.

10-NAME OF FATHER. Robert- Lee

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Bettie Lydnon

13-BIRTHPLACE OF MOTHER (State or Country). born in Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Berthia Blakeney

(Address) 15- 20. E. Madison St.

15-

Filed....., 191.....

ROBERT J. BRAUER

Registrar.

DEC 2 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from NOV 23 1921, to Dec 1 1921, that I saw h[redacted] alive on Dec 30 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Tuberculosis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) [redacted] M. D.

Dec 2, 1921, (Address) 1520 E Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Int- Auburn Cem

DATE OF BURIAL. Dec 3..., 1921

20-UNDERTAKER Mrs Robert- A Elliott

ADDRESS 1726- Oakland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59046

CERTIFICATE OF DEATH

29

D 59046

1-PLACE OF DEATH

Belvar

REGISTERED NO.....

CITY OF BALTIMORE: (No. 51 Forrest View Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. Alexander

(a) RESIDENCE. No. 51 Forrest View Ave ST.: WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Annie Alexander

6 DATE OF BIRTH (month, day, and year): Dec 1/44

7 AGE — Years: 76 — Months: 11 — Days: 28 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Furniture 066

(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Phila. Penna.

PARENTS

10 NAME OF FATHER: Thos. Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): R. Alexander 51 Forrest View ave

15 Filed DEC 2 - 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 1921, to , 19 ,

that I last saw h im alive on Nov 21 , 1921,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed): D. J. Francel M. D.

12/1 1921 (Address) 2239 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem. — DATE OF BURIAL: Dec 2 1921

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Adams

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79-010 D 59047

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 Greenmount ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Riemeyer

(a) RESIDENCE No. 548 Greenmount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. — mos. 351 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~WIFE of~~ Amelia Riemeyer

6 DATE OF BIRTH (month, day, and year) Nov 6, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	351	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas Riemeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Heinritz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Geo. Aisel (Address) 548 E Greenmount Ave

15 Filed DEC 2 - 1921, 19 ROBERT J. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1921, to Dec. 1921,

that I last saw him alive on Dec 1st, 1921,

and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo W Hemmeter, M. D.

, 19 (Address) 800 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster	Dec 3 1921
20 UNDERTAKER Peter S. Little	ADDRESS 2700 Eastern Ave

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59048 ✓ 182 D 59048

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 339 Post Hospital St.; 6 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Herman Kauffmann

(Residence in Baltimore: No. 16 n Carey st. St.; yrs. 42 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 15, 1901
(Month) (Day) (Year)

7-AGE, 20 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Herman Kauffmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Kate Foster

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Kauffmann

(Address) 16 N. W Carey St

15- DEC 2 - 1921 ROBERT J. KRAUSE Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by pistol shot

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Turley M. D.
(Coroner)

12-2, 1921 (Address) 4 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 5, 1921

20-UNDERTAKER Robt J Turner — ADDRESS 122 N Bway

Spec.—1-10-21—M&T—1500 Bks.

D 59049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 59049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Third St. ST., No WARD)

2-FULL NAME Katherine M. Lange

(a) RESIDENCE NO. 208 S. Third St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Lange

6 DATE OF BIRTH (month, day, and year) Nov. 26. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Lehmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Conrad Lange (Address) 208 S. Third St

15 Filed DEC 2 - 1921 By ROBERT J. BRUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1921, to Dec. 1, 1921, that I last saw her alive on Nov. 28, 1921, and that death occurred, on the date stated above, at 1 15 A. m.

The CAUSE OF DEATH* was as follows:

Senility 9 age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? age weakness

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews Cemetery	Dec. 3 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1718 Fleet St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59050 ✓ D 59050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 Sycamore ST. 13 WARD) 170

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Clark

(a) RESIDENCE. No. 1337 Sycamore ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Clark

6 DATE OF BIRTH (month, day, and year) Dec 25 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Clark (Address) 1337 Sycamore St

15 Filed DEC 2 1921 S. E. Mehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4 1921, to Dec. 1 1921, that I last saw her alive on Dec. 1 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical symptoms

(Signed) C F Campbell, M. D.

12/1. 1921 (Address) 3701 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Dec 3 1921

20 UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 VD 59051

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West End Maternity St. (Hosp. or WARD)

2-FULL NAME Georg F. Rosenbrock

(a) RESIDENCE NO. 3036 Armah Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Edgar T Rosenbrock

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Junker

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Balto Md.

14 Informant Geo Rosenbrock

(Address) 3036 Armah Ave

15 Filed DEC 2 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2-1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1921, to Dec 2, 1921,

that I last saw h[illegible] alive on ~~5.45~~ Dec 2, 1921,

and that death occurred, on the date stated above, at 5.45 m.

The CAUSE OF DEATH* was as follows:

Asphyxiation during birth by long compression of cord

..... (duration) yrs. mos ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? denied

(Signed) Emma J Adelhart, M. D.

12-1, 1921 (Address) 402 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 8' 1921
20 UNDERTAKER	ADDRESS
Mr-Mrs H S Funk	1838 N Patt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59052

CERTIFICATE OF DEATH.

64

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 911 Druid Hill Ave. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Ray

(Residence in Baltimore: No. 1309 Myrtle Ave, St.: 4 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: November (Month) 1880, (Day) (Year)

7-AGE: 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): O.H.S

9-BIRTHPLACE (State or Country): Balto. Md,

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Asa P. Ray

(Address) 1309 Myrtle Ave.

15- Robert P. Harrison,

Filed ..... 191.....

DEC 2-1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 5 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) No history

(Duration) yrs. mos. ds.

(Signed) J. F. Hennessy, M. D.
(Coroner)

Dec. 2 1921 (Address) 202 Eutaw Savings Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Dec 2nd, 1921

20-UNDERTAKER Samuel Hensley ADDRESS 578 W Fayette

D 59053

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 59053

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 E N. Arth av St.: 12 WARD)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Norton

(Residence in Baltimore: No. 423 E north ave St.; 50 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE ~~MARRIED WIDOWED OR DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: March 25 (Month) (Day), 1859 (Year)

7-AGE: 62 yrs. 8 mos. 5 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Ireland

PARENTS

10-NAME OF FATHER: Mathew Norton

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Ellen Jordan

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Egan

(Address) 423 E North Ave

15- Robert P. Harrison,

Filed DEC 2 1921, 191... (Deputy) Permit Clerk

REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 11/30/21 (Month) (Day), 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to, 11/30/21 191..., that I saw h.r alive on 11/30/21 191..., and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Myocarditis
(Duration) 1 yrs. ... mos. ... ds.

Contributory (SECONDARY) Gangrene of both feet
(Duration) ... yrs. 1 mos. 20 ds.

(Signed), Jas A O'Donnell M. D.

12/1/21, 191... [Address] 107 E West St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Marys Towns

DATE OF BURIAL: Dec 3, 1921

20-UNDERTAKER: W. C. Tindall

ADDRESS: 91 Fremont Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59054

D 59054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhemina Klever

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed 12/2/ 1921 Robert P. Harrison, Registrar

C2-1921 Permit clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2 1921

17

I HEREBY CERTIFY, That I attended deceased from October 17, 1921, to December 2, 1921,

that I last saw her alive on December 1, 1921,

and that death occurred, on the date stated above, at 1:00 A.M. m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture Right Hip,

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? at place

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. B. Broadus, M. D.

12/2/, 1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Dec 5 1921
20 UNDERTAKER Lilly & Zeller	ADDRESS 405 S Hoff

mation should be carefully supplied. A FULL and CORRECT answer should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rolled out of Bed
at Hospital

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59055

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 S. Second St.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Morgan.

(a) RESIDENCE. No. 917 S. Second ST., 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Hugh A. Morgan

6 DATE OF BIRTH (month, day, and year) March 5th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Burlage.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Albert Morgan 917 S Second St

15 Filed DEC 2 1921 Robert P. Hartigan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 1 1921

17 I HEREBY CERTIFY, That I attended deceased from 11 30, 1921, to 12 1, 1921, that I last saw her alive on 11 30, 1921, and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Hanna B. Tillow M. D.

12/1, 1921 (Address) 315 Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec 5th 1921
20 UNDERTAKER	ADDRESS
Lilly & Geiler.	405 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59056

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3027 Elliott ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Feehley.

(a) RESIDENCE. NO. 3027 Elliott ST., 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Timothy Feehley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Tracey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Timothy F. Feehley, 3027 Elliott St.

15 Filed Dec 2 - 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1921, to Nov 30, 1921, that I last saw h[illegible] alive on Nov 29, 1921, and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage & Nephritis (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. McAvoy, M. D.

12/1, 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cemetery	Dec 3d 1921
20 UNDERTAKER Lilly & Sulser	ADDRESS 403 S. Hoffman

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59057

CERTIFICATE OF DEATH.

39

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3220 Fait Ave ST.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Williams

(a) RESIDENCE. No. 3220 Fait Ave ST., 76 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Williams

6 DATE OF BIRTH (month, day, and year) May 26-1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Alfred Tagg.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann Cuby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Edward. Williams

(Address) 3220 Fait Ave.

15 Filed DEC 2 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Nov 29, 1921, that I last saw h er alive on Nov 29, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue & Throat (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos J. McAvoy, M. D.

12/2 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Dec. 3 1921

20 UNDERTAKER Lilly & Zeile

ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—B. P. Co.—1000 Bks.

D 59058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59058

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O'Neil

(a) RESIDENCE. NO. 1830 Wallbrook Ave. ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Widowed~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 2 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. Balto.

PARENTS

10 NAME OF FATHER Jno. O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Edw J Lupan

(Address) 1817 Druid Park Ave

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29. 1921, to Nov. 30, 1921, that I last saw her alive on Nov. 30, 1921, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine, Blood Wrm, P.S. & S.

(Signed) Frank C. Masino, M. D.

(Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	12-3 1921

20 UNDERTAKER J. G. Moran ADDRESS E. Balto

12-1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 59059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59059

CERTIFICATE OF DEATH.

28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 601 Brook Ave ST., 27 WARD)

2-FULL NAME Thomas William Sims

(a) RESIDENCE No. 601 Brook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced (write the word) Married

5a If married, widowed or divorced (or) ~~WIFE~~ of Edna B. Sims

6 DATE OF BIRTH (month, day, and year) May 1 - 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 007

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Conrad Sims

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Carrie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edna B. Sims

(Address) 1508 Graham Court Arlington

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

C2-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30/21 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 19 21 to Nov 30, 19 21, that I last saw him alive on Nov 30 19 21, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Acute Pulmonic Tuberculosis existing about (duration) 8 yrs. 1 year ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert F. Webster, M. D.

Dec. 19 21 (Address) 703 St Paul Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL 12/3 19 21

20 UNDERTAKER William Corbo ADDRESS 508 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PHONE
TON 341

ALBERT G. WEBSTER, M. D.
OVERLEA, MD

OFFICE HOURS
8 TO 10 A. M.
6 TO 8 P. M.

D 59059

Balto. Md.
Jan. 10? 1922.

Dr. C. Hampson Jones,
Health Commissioner,
Balto. Md.

Dear Doctor,

I wish to make a correction in the death certificate of Thomas Lunz, to change the duration of illness from two years to one year. This correction was sent to the State Board of Health, also.

Trusting this is satisfactory, Iam,

Very truly yours,

A. G. Webster M.D.

JAN 12 1922

D 59060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

184 D 59060

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 331 S. Spring St. 3 X WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louisa Dagenhardt

(Residence in Baltimore: No. 331 S. Spring St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1855 (Year)

7-AGE, 66 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stand in Market
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Dagenhardt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Scherer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Benjamin

(Address) 1410 Beech Ave

15-

Filed ..., 191...

Robert P. Harrison, Registrar.
Burial Permit Clerk.

C 2 - 1921

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, on or about Nov. (Month) 27 (Day), 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration (Carotid)
Homicide
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Asphyxia
(Duration) yrs. mos. ds.

(Signed) Geo Emlen Blades M. D.
(Coroner)
Dec 7/28 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Dec 3, 1921
20-UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59061

D 59061

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Watson (or Simeon Watson)

(a) RESIDENCE. No. 573 Oxford St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882 or 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
39 or 43	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed DEC 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1 1921

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1921, to December 1, 1921, that I last saw him alive on November 30, 1921, and that death occurred, on the date stated above, at 12:05 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde O'Neill, M. D.

12/1/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 4 1921
20 UNDERTAKER	ADDRESS
Daniel Easton	Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Hosey)

D 59062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59062

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Transit to University Hospital REGISTERED NO. C 79

CITY OF BALTIMORE (No. 16 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Hosey

(Residence in Baltimore: No. 1005 W Hatcoat St - St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Marrd

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Robt Hosey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Penna Ave

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.)

thereon and from the evidence obtained by said ~~(Inquest, au-~~

~~topsy or~~ inquiry.) find that said deceased came to h-s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Dont Know

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) M K Gormley M. D. (Coroner.)

12-1- 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Dec 3, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pk ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

3 1921

3	192	Burial Permit Clerk. Registrar.	Daniel Carton	Pk ac

D 59063 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59063

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Stoker & Mulberry, St. 19 Ward)

2-FULL NAME Sallie Fairstick.

(Residence in Baltimore: No. Baptist Home. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct. 21, 1854 (Month) (Day) (Year)

7-AGE, 67 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Inmate of
(b) General nature of industry, business, or establishment in which employed (or employer)..... Baptist Home

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, John R. Clemens

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Hartley

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sylvia Helmes

(Address) 2301 N. Charles St.

15- Robert P. Harrison,

Filed DEC 3 1921 191 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 19 21 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held by Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Duration..... yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Barrel Consumption

Duration..... yrs. 2 mos. ds.

(Signed) C. E. Riddell M. D. (Coroner.)

Dec 1 1921 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 3 1921

20-UNDERTAKER John Cuddihee ADDRESS 120 W. Fayette St.

NB—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59064

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59064

CERTIFICATE OF DEATH.

X-41

1-PLACE OF DEATH Howard A. Kelly Hospital REGISTERED NO. 14

CITY OF BALTIMORE: (NO. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Sherman King

(a) RESIDENCE. NO. Princeton W. Va ST., WARD Princeton W. Va
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R Ry Brakeman

(b) General nature of Industry, business, or establishment in which employed (or employer) R Ry

(c) Name of employer Virginian R Ry.

9 BIRTHPLACE (city or town) Jopbet W. Va.
(State or country)

PARENTS

10 NAME OF FATHER Henry A. King

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Effie Ferguson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Leonard W. King
(Address) Princeton W. Va

15 Filed 19 Robert P. Harrison, Registrar
DEC 3 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2/1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1921, to Dec. 2, 1921, that I last saw h m alive on Dec. 2, 1921, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

General Sarcomatosis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 16, 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam

(Signed) Arthur C. Primrose, M. D.

Dec. 2 1921 (Address) 1418 Eaton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Princeton West Virginia	Dec. 3 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Retro peritoneal gland involved. Hard to tell where it originated

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59065

D 59065

CERTIFICATE OF DEATH.

109

REGISTERED NO.

1-PLACE OF DEATH Confederate Womans Home

CITY OF BALTIMORE: No 1020 Linden ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Brooks

(a) RESIDENCE. No. 1020 Linden ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~ (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1847

7 AGE: 74. Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER William Brant

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant James R. Wheeler
(Address) Commonwealth Bank

15 Filed DEC 3 1921, 19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27th, 1921, to Dec 1st, 1921,
that I last saw her alive on Dec 1st, 1921,
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:

Volvulus

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Henry C. Gale, M. D.

, 19 (Address) 240 N. Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: 12-3 1921

20 UNDERTAKER: Henry W. Jent Funeral Home

ADDRESS Richard & Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59066

D 59066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 W. Lombard St. WARD) 20

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Smith

(a) RESIDENCE NO. 2413 W. Lombard Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Smith

6 DATE OF BIRTH (month, day, and year) 1882 1884?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 E Baltimore St

15 Filed ....., 19 .... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1920, 19..., to Dec 2, 1921, that I last saw him alive on Dec 2, 1921, and that death occurred, on the date stated above, at 130 P m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chr. Valv. Heart Dis.
(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... D. S. Wallerstein, M. D.

, 19 (Address) 6 S. Exeter St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newport News Va — DATE OF BURIAL 12/3 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C3 1921 Robert P. Harrison, Registrar

Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59067

D 59067

CERTIFICATE OF DEATH.

152

REGISTERED NO.

1-PLACE OF DEATH 907 Fawn St.

CITY OF BALTIMORE: (No.) ST. 3 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daly Maurorose.

(a) RESIDENCE. No. 907 Fawn St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 15 min.
	—	—	—	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Pasquale Maurorose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Giro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant (Address) Johns Hopkins Records Off.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1921, to Dec 2, 1921,

that I last saw him alive on Dec 2, 1921

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

asphyxia Pallida

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical findings

(Signed) Helen Vincent, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent

DATE OF BURIAL: Dec 3 1921

20 UNDERTAKER: Wendell Wiffel

ADDRESS: 3781 Mmn

C3

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Pettit

D 59068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59068

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Maine Ave ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jane Pettit

(a) RESIDENCE NO. ~~Same~~ 4101 Maine Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas F. Pettit

6 DATE OF BIRTH (month, day, and year) April 6, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X None

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. J. Coulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary J. Quigg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Jay T. Nuttall

(Address) 4101 Maine Ave

15 Filed Robert P. Harrison, 19 Registrar

3 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1921, to Dec. 1, 1921,

that I last saw h- alive on Dec. 1, 1921

and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Herbert C. Blake M. D.

, 19 (Address) 1014 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 3 19
20 UNDERTAKER W. J. McNeil & Son	ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 59069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59069

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Arbutus Ave near Washington Road ST., 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Baierlein.

(a) RESIDENCE NO. Arbutus Ave. near Washington Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced (or) WIFE of: Michael Baierlein.

6 DATE OF BIRTH (month, day, and year): June - 1838.

7 AGE: Years 83 Months 11. Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Wehnert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dorothea Dec 2 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Michael Baierlein (Address): 1713 N. Regester

15 Filed 1921 Robert P. Ferrier, Burial Permit Clerk. Registrar

C 3

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1921, to Nov 29, 1921, that I last saw her alive on Nov 30, 1921, and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH* was as follows:

Heart Disease Valvular

(duration) 10 yrs. 10 mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Raymond Thomas M. D.

(Address) Lutherville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glenburnie Cem. DATE OF BURIAL: Dec. 4 1921

20 UNDERTAKER: Woodcock ADDRESS: 502 E. Hoffman Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 59070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59070

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH St Vincents Infant Asylum

CITY OF BALTIMORE, (No. 1401 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cashman

(a) RESIDENCE NO. 1401 Division ST., 14 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19-1921

7 AGE — Years: — Months: 6 Days: 10 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Mary Cashman

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: St Vincents

(Address) 1401 Division St

15 Filed ... 19... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1921, to Nov 29, 1921, that I last saw h[illegible] alive on Nov 29, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinique

(Signed) Chas Heburton M. D.

(Address) 1504 Linden Ave

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Dec 3 1921

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1527 W North Ave

DEC 3 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59071

D 59071

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Cress

(a) RESIDENCE. NO. 1904 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? 65 yrs 5 mos 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Adam F. Cress

6 DATE OF BIRTH (month, day, and year) June 9- 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Deitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Steigerwald
(Address) 1904 Orleans St.

15 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 21. 1921. to Dec 1. 1921. that I last saw h[illegible] alive on Nov 30. 1921. and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

12/1. 1921 Signed A. C. Heyer, M. D.
(Address) 2600 E. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	12/4 1921
20 UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans St

mation should be carefully supplied. Also, should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59072

CERTIFICATE OF DEATH.

D 59072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 W. Saratoga ST.; 4 WARD)

REGISTERED NO. C 78

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E. Fritz

(Residence in Baltimore: No. 739 W. Saratoga St.; 18 yrs., 11 mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	single

6-DATE OF BIRTH, 12 (Month) 29 (Day), 1902 (Year)

7-AGE,	If LESS than 1 day,
18 yrs. 11 mos. X ds.	hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Jacob Fritz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Abel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. G. Muller

(Address) 739 W. Saratoga St.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/28 1921, to 11. 29 1921, that I saw her alive on 11. 29 1921, and that death occurred, on the date stated above, at 11:50 p m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

Producing Obstruction

(Duration) 1 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 1 yrs. 3 mos. X ds.

(Signed) P. Blilson M. D.

12/1, 1921. (Address) 1124 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemtry	Dec 3 21, 191...

20-UNDERTAKER Harry H. Witzke ADDRESS 1531 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59073

D 59073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Municipal Hospital ST.: 76 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Barnes

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joshua Barnes

11 BIRTHPLACE OF FATHER (city or town) Balto., (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto., (State or country) Maryland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed Dec 3 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from November 29 1921, to November 30 1921, that I last saw him alive on November 29, 1921, and that death occurred, on the date stated above, at 4:15 A. M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Insufficiency

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Norell, M. D.

11/30/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS Dec 3 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15-12-60 59074

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 59074

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Saddler

(a) RESIDENCE. No. 800 S. Streeper ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-25-21

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) J H Hospital

PARENTS

10 NAME OF FATHER George Saddler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Graceonville Md

12 MAIDEN NAME OF MOTHER Effie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Graceonville Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Baltimore

15 Filed DEC 3 1921 No. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-25, 1921, to 11-25, 1921, that I last saw him alive on 11-25, 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 4 hrs.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? Weight 1 lb. 14½ oz.

(Signed) Horace G. Stewart, M. D.

12/1, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL. DEC 3 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

D 59075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59075

CERTIFICATE OF DEATH.

159

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 738 N Bouldin ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie E Bostlein

(Residence in Baltimore: No. 738 N Bouldin St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June 15, 1904
(Month) (Day) (Year)

7-AGE, 17 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Solderer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Urban Bostlein

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Lena Dolle

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Urban Bostlein

(Address) 738 N Bouldin St

15-

Robert P. Harrison,
Circuit Clerk.

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Henry Ryan Woolley M. D.
(Coroner.)

Dec 7, 1921 (Address) 1800 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Matthews Cemetery	Dec 5, 1921
20-UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59076 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59076

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1426 John St. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Coyle

(a) RESIDENCE. No. 1426 John St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos Coyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Kehoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Coyle
(Address) 1426 John St.

15 Filed 1921 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 26 1921 to Dec 1 1921.

that I last saw her alive on Dec 1 1921.

and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism (duration) yrs. 6 weeks ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Mary F Vaughan M. D.

12. 2. 1921 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Govans	12/5 1921
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	1186 W. Mt Royal ave

C3

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59077

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Colbert

(a) RESIDENCE. No. 706 E. Preston St. St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed 12/2/, 19 21 Registrar

C 3 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1919, to December 2, 1921, that I last saw her alive on December 1, 1921, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde Mitchell, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 5 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Preston St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59078

D 59078

CERTIFICATE OF DEATH.

K 74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Druckenbrod

(a) RESIDENCE. NO. 239 Maine St Meluchen, N.J. WARD. Meluchen N.J.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-1-10

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work spinner 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER Samuel Druckenbrod

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Edna Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

C 3

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1921, to 12-2, 1921, that I last saw h[illegible] alive on ....., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Non malignant.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N.

Did an operation precede death? yes Date of 12/2/21

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy.

(Signed) David Holman, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Meluchen N. J.

DATE OF BURIAL Dec 3 1921

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 N Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59079

CERTIFICATE OF DEATH.

50-091 D 59079

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1622 Eutaw Place St.: 14 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mann

(a) RESIDENCE. No. 1622 Eutaw Place St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Mann

6 DATE OF BIRTH (month, day, and year): Nov 6th 1846

7 AGE: Years 75 Months — Days 25 If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: W. H. Kafenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mathilda Sake

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs H. Strine (Address) 1622 E.P.

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from January 8 1913, to Dec 1st 1921, that I last saw h[er] alive on Dec 1st 1921, and that death occurred, on the date stated above, at 10.05 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; angina pectoris; Myocarditis

Symptoms (duration) 9 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

Dec 2, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rhebb Shalom DATE OF BURIAL: Dec 4th 1921

20 UNDERTAKER: Harry Sondheim ADDRESS: 1818 W. Baltimore St.

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59080

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59080

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 Druid Hill Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise R. M. Parm

(a) RESIDENCE. NO. 1915 Druid Hill Ave ST.. WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 16-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sierra Leone Africa

PARENTS

10 NAME OF FATHER James McCall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Louise McCard

(Address) 19 Druid Hill Ave

15 Filed 1921 Robert P. Harrison, Burial Permit Clerk. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1921, to DEC 1 1921, that I last saw h Er alive on DEC 1 1921, and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation & Hypertrophy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted, if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

12/2 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Dec. 4 1921

20 UNDERTAKER George H. Holland

ADDRESS 1631 Druid Hill Ave

...ation should be carefully supplied. AGE should be ...y be properly classified. Exact statement of OC... CAUSE OF DEATH in plain terms, so that it may be ...TION is very important. See instructions on back of ...k of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59081

CERTIFICATE OF DEATH.

64 D 59081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Druid Hill ST.: 11 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fannie Cooper

(a) RESIDENCE. No. 1205 Druid Hill ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy Hazelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Information given by Mrs Smith
(Address) 1205 Druid Hill Ave

15 Filed Dec 8 1921 Robert P. Harrison Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 — 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1921, to Dec. 1 —, 1921, that I last saw h alive on Dec. 1 —, 1921, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward J. Wheatley, M. D.

12/1/ 19 21 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Auburn Cem	Dec 5 1921
20 UNDERTAKER Geo. H. Holland	ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59082

D 59082

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 2008 Brent (St.) 14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Brown

(a) RESIDENCE. No. 2008 Brent St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Brown

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Laundry Work

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Philip Dorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Robert Brown ~~2008 Brent St.~~

15 Filed DEC 4 - 1921 Registrar

Burial permit issued by Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 4 1921 to Dec 1 1921

that I last saw her alive on Nov 30 1921

and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Ileo Col. T.S. with tube. Sulfan infection of bowel peritoneum (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Possibly a primary tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? cannot say

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Earl Short M. D.

12/3 1921 (Address) 1512 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Mt. Auburn Cemetery Dec 1 1921

20 UNDERTAKER James H. Dennis ADDRESS 1312 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59083

CERTIFICATE OF DEATH.

78 D 59083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 Laurens ST., 14 WARD)

2-FULL NAME Rebecca Russ

(a) RESIDENCE NO. 547 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30, 1903

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs or... min.
	18		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co
(State or country) Va

PARENTS

10 NAME OF FATHER Arthur Russ

11 BIRTHPLACE OF FATHER (city or town) Lancaster Co
(State or country) Va.

12 MAIDEN NAME OF MOTHER Chana Tomlin

13 BIRTHPLACE OF MOTHER (city or town) Lancaster
(State or country) Va

14 Informant Arthur Russ
(Address) 547 Laurens St

15 Filed DEC 4 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1921, to Dec 1, 1921, that I last saw h[illegible] alive on Dec 1, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) E Williams Fray M. D.

12/2, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Co. Va. Mariaskin Meth. Ch. DATE OF BURIAL Dec 4 1921

20 UNDERTAKER James H. Dennis ADDRESS 1303 Preston

MATION SHOULD BE CAREFULLY SUPPLIED. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

59082 HEALTH DEPARTMENT—CITY OF BALTIMORE 59082

D 59084 CERTIFICATE OF DEATH. 97 D 59084

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 2109 Mc Culloh St. ST.; 14 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Jones

(Residence in Baltimore: No. 2109 Mc Culloh St. St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Married

6-DATE OF BIRTH. March 4, 1857 (Month) (Day) (Year)

7-AGE. 67 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work: farmer (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE. (State or Country). Calvert Co, Md.

PARENTS.
10-NAME OF FATHER. Carlin Chambers
11-BIRTHPLACE OF FATHER (State or Country). Md.
12-MAIDEN NAME OF MOTHER. Priscilla Jones
13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robt. Jones
(Address) 2109 Mc Culloh St.

15- FILED DEC 4 - 1921 ROBERT J. BRAUER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 1, (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(Duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) no history
(Duration) yrs. mos. ds.
(Signed) J. T. Hennessy, M. D. (Coroner)
Dec 3, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Hill Ave. DATE OF BURIAL. Dec 4 1921
20-UNDERTAKER Edward Ruppert ADDRESS 1468 Eutaw St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59085

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 W. Lexington ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fielden Bowie Boswell

(Residence in Baltimore: No. 1530 West Lexington St. St. 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (*Write* the word.) Widower

6-DATE OF BIRTH, February 20, 1839 (Month) (Day) (Year)

7-AGE, 82 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Calvert County Maryland

PARENTS.

10-NAME OF FATHER, William H. Boswell

11-BIRTHPLACE OF FATHER (State or Country), U. S. A.

12-MAIDEN NAME OF MOTHER Phoebe Finch

13-BIRTHPLACE OF MOTHER (State or Country), U. S. A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ingle B. Boswell

(Address) 1530 W. Lexington St.

15. Filed DEC 4 - 1921 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 1, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Dec. 1 1921, that I saw him alive on Dec. 1. 1921, and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease
Aortic regurgitation

(Duration) yrs. 4 mos. 22 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. — mos. ds.

(Signed) Henry M. Stevenson M. D.

12/3, 191.. (Address) 1022 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec. 5, 1921

20-UNDERTAKER George J. Smith — ADDRESS 100 N. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59086

CERTIFICATE OF DEATH.

9/084 D 59086

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 301 Preston Pl ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Green

(a) RESIDENCE. No. 301 Preston Pl ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nd

(b) General nature of industry, business, or establishment in which employed (or employer) nd

(c) Name of employer nd

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Greene

11 BIRTHPLACE OF FATHER (city or town) X
(State or country) Calvert Co Maryland

12 MAIDEN NAME OF MOTHER Emma Jones

13 BIRTHPLACE OF MOTHER (city or town) X
(State or country) Calvert Co Maryland

14 Informant Joseph Greene (Father)
(Address) 301 Preston St

15 Filed DEC 4 - 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 20th, 1921, to Dec 3rd, 1921, that I last saw h[illegible] alive on Dec 3rd, 1921, and that death occurred, on the date stated above, at 1250 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia or Capillary Bronchitis

(duration) X yrs. X mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) X yrs. X mos. 7 ds.

18 Where was disease contracted if not at place of death? nd

Did an operation precede death? no Date of nd

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) [illegible], M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Dec 5 1921
20 UNDERTAKER [illegible]	ADDRESS 631 Mount Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 59087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 2013 E. Eager St., 7 Ward)

2-FULL NAME Henry H. Rexroath

(a) RESIDENCE. No. 2013 E. Eager St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary J. Rexroath.

6 DATE OF BIRTH (month, day, and year) 4. 6. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) Cement Worker

(c) Name of employer See Balto. Md

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Rexroath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary J. Rexroath

(Address) 2013 E. Eager St.

15 Filed DEC 4 - 1921 ROBERT F. KRAJTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 2. 1921

17 I HEREBY CERTIFY, That I attended deceased from November 8, 1921, to December 2, 1921

that I last saw h[illegible] alive on December 1, 1921

and that death occurred, on the date stated above, at 12.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interst. Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Hearts Dis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles H. A. Meyer, M. D.

12/2 1921 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Dec 5th 1921
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 59088

HEALTH DEPARTMENT—CITY OF BALTIMORE

1725 59088

CERTIFICATE OF DEATH.

O.K. H.K. Gorsuch coroner M.D.

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No.) Lombard & Greene Sts ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bambievice

(a) RESIDENCE NO. 520 Columbia Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 0-0-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 540

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer Car Barns

(c) Name of employer Metro Railways -

9 BIRTHPLACE (city or town) (State or country) Lithuania -

PARENTS

10 NAME OF FATHER Matthew Bambievice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Agata Cernuleuse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Hospital Records.
(Address)

15 Filed DEC 4 - 1921 19 ROBERT J. FRASIER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2 1921.

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1921, to Dec 2, 1921, that I last saw him alive on 12/1, 1921, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Septic Meningitis.

Over

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Fracture base skull

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 520 Columbia Ave, Balto Md.

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical Finding.

(Signed) Cyrus D. Horine, M. D.

, 19 (Address) University Hospital Balto Md (F.H.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemetory	Dec 5 19
20 UNDERTAKER	ADDRESS
John Grebliavckas	425 S Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fall down steps

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59089

D 59089

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Providence Hosp ST., 17 WARD)

2-FULL NAME Isaac Watkins

(a) RESIDENCE NO. 615 Dolphin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Watkins

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER John Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Clarkson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mary Carpenter. 615 Dolphin

15 Filed DEC 4 - 1921 19 ... Registrar. LOUIS A. KLAUS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30/1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1921, to Nov. 30, 1921, that I last saw him alive on Nov. 30, 1921, and that death occurred, on the date stated above, at 6:00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis

(duration) yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. ... mos. 20 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H Tompkins, M. D.

12/6/1921 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 4 1921

20 UNDERTAKER Samuel Hemsley

ADDRESS 78 Madison

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 59090

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 N. Fulton Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry G. Knipschilds

(Residence in Baltimore: No. 1339 N Fulton Ave St.; 61 yrs., 8 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 4, 1860
(Month) (Day) (Year)

7-AGE, 61 yrs. 8 mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): for self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, August Knipschilds

11-BIRTHPLACE OF FATHER (State or Country), Europe

12-MAIDEN NAME OF MOTHER Bettie Brockman

13-BIRTHPLACE OF MOTHER (State or Country), Europe

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Henry G. Knipschilds

(Address) 1339 N. Fulton Ave

15- Filed DEC 4 - 1921, 191.... ROBERT J. KRAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 2, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1921, to Dec 2 1921, that I saw him alive on Dec 2 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Throat

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration) yrs. 3 mos. ds.

(Signed) C. N. Dorsey M. D.

Dec 3, 1921. (Address) 1817 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Dec 5, 1921.

20-UNDERTAKER Jos Foresdens Son — ADDRESS 217 S Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59091

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Mt Royal Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Morris

(a) RESIDENCE. No. 1218 Mt Royal Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Morris.

6 DATE OF BIRTH (month, day, and year) Jan. 10 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Restaurant.

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Isaac Morris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jettie Rosenthal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Morris. (Address) 1218 Mt. Royal Ave.

15 Filed DEC 4 - 1921 ROBERT J. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to Dec 2, 1921, that I last saw h.. alive on December 2, 1921, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension - Arteriosclerosis
Chronic nephritis

(duration) 2 yrs (?) mos. ds.

CONTRIBUTORY (Secondary) Apoplexy. + Low

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Fred T. Smith, M. D.

. 19 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Shalom Cem	Dec 5 1921
20 UNDERTAKER	ADDRESS
J. Abreus & Co	16 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

J. AHRENS & CO.

Spec.—6-9-19—H. P. Co.—1000 Bks. FUNERAL DIRECTORS AND EMBALMERS

D 59092 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59092

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1199 N. Fulton Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Archer

(a) RESIDENCE. NO. 1218 Mt Royal Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 85 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Mulatto	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Archer

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
85	✓			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md,

PARENTS

10 NAME OF FATHER David Rosenstock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Bernbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Bernbaum

(Address) 1199 N Fulton Ave

15 Filed DEC 4 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 21

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 - 1921, to Dec 2, 1921, that I last saw her alive on Dec 2, 1921, and that death occurred, on the date stated above, at 6-P.M.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Wm S Love, M. D.

19 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (Consult reverse side for additional space.)

FUNERAL DIRECTORS AND EMBALMERS

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cem

DATE OF BURIAL: DEC 4 1921

20 UNDERTAKER: J Ahrens Co

ADDRESS: 16 W Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59093

CERTIFICATE OF DEATH.

150 D 59093

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Harlem Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elda Jane Duncan

(Residence in Baltimore: No. 1015 Harlem Ave St.; ....yrs. ....mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. (Month) 14 (Day), 1921 (Year)

7-AGE.	If LESS than 1 day,
....yrs. ....mos. 19 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Frank A Duncan

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Lucy A Wright

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy W. Duncan

(Address) 1015 Harlem ave.

15- [illegible] REGISTRAR

Filed DEC 4 1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30 1921, to Dec 3 1921, that I saw h[illegible] alive on Dec 3 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Walter B. Bacon M. D.

12/3, 1921. (Address) 1[illegible] Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemet — DATE OF BURIAL, Dec. 5, 1921

20-UNDERTAKER Wilbur H. Shriver — ADDRESS 1018 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Eunice

HEALTH DEPARTMENT—CITY OF BALTIMORE

59094

CERTIFICATE OF DEATH.

X138D 59094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Helen Eunice

(Residence in Baltimore: No. Rossville, Md St.; ... yrs., mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, — (Month) — (Day) 1900 (Year)

7-AGE, 20 yrs. 9 mos. ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, — James Archer

11-BIRTHPLACE OF FATHER (State or Country), — Md.

12-MAIDEN NAME OF MOTHER — Unknown

13-BIRTHPLACE OF MOTHER (State or Country), — Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Eunice

(Address) Rossville Stemmers Run Md.

15-

Filed DEC 4 - 1921 ROBERT A KRAUTER Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec — 2, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1911, to Dec 2 1921, that I saw h[er] alive on Dec 2 — 1921, and that death occurred, on the date stated above, at 1 0 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Eclampsia

(Duration) ... yrs. ... mos. 1 ... ds.

(Signed) H. C. Wallick M. D.

Dec 2, 1921. (Address) Franklin Square Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 4 ds. In the State 9 yrs. mos. ds.

Where was disease contracted, if not at place of death? Do not know

Former or usual residence Rossville, Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Dec 5, 1921

20-UNDERTAKER	ADDRESS
Wilbur H. Shreve	1018 E. Monument av

Remarks .....

Childbirth

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59095

D 59095

CERTIFICATE OF DEATH.

37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2923 Walbrook St., (Ward) 46

2-FULL NAME Harry Franklin Wilcox

(a) RESIDENCE NO. 2923 Walbrook St. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gillian E. Wilcox

6 DATE OF BIRTH (month, day, and year) July 17 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER E. B. Wilcox

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary J. Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E. B. Hopkins

(Address) 4104 Belle Ave

15 DEC 4 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3. 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Dec 3, 1921,

that I last saw him alive on Dec 3, 1921,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Texas

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julian S. Bishop, M. D.

, 19 (Address) 930 N. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 12/5 1921

20 UNDERTAKER Wm. J. Tickner Son's

ADDRESS North & Pennsylvania

Burial Form 1 Ulert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. John. J. Bishop

930 N. Calvert St

Luetic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59096 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59096

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 656 Indiana Ave., Westport ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Moore Royal

(a) RESIDENCE. No. 656 Indiana Ave, Westport ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Anna Kuethe Royal

6 DATE OF BIRTH (month, day, and year) 26 Jan. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping Clerk

(c) Name of employer None within 2 yrs. Last Camp Holabird - U.S. Army

9 BIRTHPLACE (city or town) Moorehead City
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Martin L. Royal

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Annie Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Mrs. Mrs. Anna Kuethe Royal
(Address) 656 Indiana Ave, Westport

15 Filed DEC 4 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2nd Dec. 1921

17

I HEREBY CERTIFY, That I attended deceased from 26 November, 1921, to 2nd December 1921, that I last saw him alive on 1st December, 1921, and that death occurred, on the date stated above, at 4.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

6 years (duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Examination

(Signed) Alfred Marcus, M. D.

2 Dec. 1921 (Address) 234 Maryland Ave, Westport

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	12/5 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-19-21 M&T 1500 Blks.

D 59097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 59097

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 W. Hamburg ST. 23 WARD)

2-FULL NAME Amelia Boyce

(a) RESIDENCE NO. 213 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 8 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Boyce.

6 DATE OF BIRTH (month, day, and year) March 17, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Boone

11 BIRTHPLACE OF FATHER (city or town) Howard Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Blue

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant Rose Anderson

(Address) 743 Dover St

15 Filed DEC 4 - 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov, 26, 1921, to Dec, 1, 1921, that I last saw h.. alive on Nov, 30, 1921, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Dunn Franklin, M. D.

12/3, 1921 (Address) 1111 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 4 1921
20 UNDERTAKER	ADDRESS
Chas Geo K. Hooper	406 W Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59098

CERTIFICATE OF DEATH.

79

D 59098

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 Colvin ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Carey

(Residence in Baltimore: No. 229 Colvin St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 11 (Day), 1852 (Year)

7-AGE, 69 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Laban McLaughlin

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Martin

(Address) 229 Colvin

15-DEC 4 - 1921

Filed....., 191.... ROBERT J. KRAUTER Registrar

Bodily Fatal Unit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 2 1921, that I saw her alive on Dec 1 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(Duration) yrs. 2 mos. ds.

(Signed) William E Burton M. D.

Dec 2, 1921 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cooquen Cem. DATE OF BURIAL, Dec 5., 1921

20-UNDERTAKER Thos J. F. Locke ADDRESS 1302 Jefferson St

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—(69-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59099 — 15359 — 92 D 59099

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Stankiewicz

(a) RESIDENCE. No. 119 South Spring St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	15		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Stankiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Helena ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed . 19 Registrar

DEC 4 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 25th, 1921, to Dec 3rd, 1921, that I last saw her alive on Dec 3rd, 1921, and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Pneumococcus meningetis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Fluid Examination.

(Signed) Horace G. Stewart, M. D.

12/3, 19.. (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Dec 5 1921
20 UNDERTAKER	ADDRESS

MR. S. KING, N. S. PINE FUNERAL DIRECTORS

In St Fr

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 59100

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 59 Darley St 13 WARD)

2-FULL NAME Annie B. Shaubberger

(Residence in Baltimore: No. 59 Darley St St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) W

6-DATE OF BIRTH, Sept 2 (Month) 2 (Day) 1921 (Year)

7-AGE, 0 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Peter Shaubberger

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Shaubberger

(Address) 59 Darley St

15-

Filed DEC 4 1921, 191.... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 3 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Dec 4, 1921 (Address) 3632 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Patrick's — DATE OF BURIAL, Dec 5, 1921

20-UNDERTAKER N. S. FINK — ADDRESS

FUNERAL DIRECTORS
1825 W. PRATT STREET

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59101

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59101

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2223 W. Balto, St., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo C Day,

(Residence in Baltimore: No. 2223 W. Balto St.,

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, Aug. 24, 1857
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Hazen P. Day

11-BIRTHPLACE OF FATHER (State or Country), New Hampshire

12-MAIDEN NAME OF MOTHER Agnes Murray.

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Hoffman

(Address) 2236 W. Baltimore St.

15- Filed DEC 4 - 1921, 191.... ROBERT B KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 1 —, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Duration

CONTRIBUTORY (Secondary)

Duration

(Signed) G. C. Blades M. D.
(Coroner.)

Dec 6 1921 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Dec 5th, 1921
20-UNDERTAKER	ADDRESS
Wm J Hartwell	2236 W. Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59102

CERTIFICATE OF DEATH.

120 D 59102

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N. Kenwood Ave ST., 6 WARD)

2-FULL NAME Alfred Samuel Mavel

(a) RESIDENCE No. 13 N Kenwood Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Ann Mavel

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	75	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Church Home & Inf. Seaford, Del.

9 BIRTHPLACE (city or town) (State or country) Seaford, Del.

PARENTS

10 NAME OF FATHER Wm. Thos. Mavel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Seaford, Del

12 MAIDEN NAME OF MOTHER Catherine Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Seaford, Del.

14 Informant Raymond J. Mavel

(Address) 130 Kenwood Ave.

15 Filed DEC 4 - 1921 ROBERT J. CRAWFORD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 6, 1921, to Dec. 3, 1921,

that I last saw him alive on Dec. 3, 1921,

and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy

Chronic interstitial nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) uraemic coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? No special test

(Signed) Jack. F. Mogan M. D.

, 19 (Address) 6 E. Eglad St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Dec 7 1921
20 UNDERTAKER Funeral Jenkins E. J.	ADDRESS 1239 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 59103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59103

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3213 O'Donnell ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Busch

(a) RESIDENCE. No. 3213 O'Donnell ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. - mos. - ds. How long in U. S., if of foreign birth? 66 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or WIFE of)~~ Katharine Busch

6 DATE OF BIRTH (month, day, and year) Nov. 14. 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	-	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired) 1880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Rev. Wm. Batz
(Address) 923 S. East Ave

15 Filed DEC 4 - 1921 ROBERT J. BRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1921, to Dec 2, 1921, that I last saw him alive on Dec 2, 1921, and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Gall Cholicystitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) My overdatis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nathan J. Davidow, M. D.

, 19 (Address) 3035 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz	Dec 5 1921
20 UNDERTAKER	ADDRESS 1739
Zirkler + Zirkler Per. [illegible]	Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 59104

CERTIFICATE OF DEATH.

D 59104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Mc Donogh ST., 7 WARD)

2-FULL NAME Florence Burgan Thompson

(a) RESIDENCE NO. 1016 Mc. Donogh ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 12 1863

7 AGE — Years: 58 | Months: 4 | Days: 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thos. Getzendanner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma M. Wilcox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Estelle Correa

(Address) 62 Mc Donogh

15 Filed DEC 4 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 8th 1921 to Dec 1st 1921, that I last saw h[illegible] alive on Dec 1st 1921, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Dec 7th 1921 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Dec 5 1921

20 UNDERTAKER: Dirkler & Dirkler — ADDRESS: 1739 Eager

Dirkler & E. J. S.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59105

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 59105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1231 Valley (St.) 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna T. Sullivan

(a) RESIDENCE. No. 1231 Valley St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27/49

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Hogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Hogan (Address) 1231 Valley St.

15 FILED DEC 4 - 1921

ROBERT J. KRAUTER
Registrar
Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4. 1921, to Dec. 2. 1921, that I last saw her alive on Dec. 2. 1921, and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) F. D. Pebel M. D.

, 19 (Address) 1001 Dorquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Dec	5 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.

Spec.—6-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59106

CERTIFICATE OF DEATH.

40 D 59106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2512 E. Preston St. 8 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Fleischmann

(a) RESIDENCE. No. 2512 E. Preston St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER John Fleischmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Catherine Denerling.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Elizabeth Feldmann 2512 E. Preston St.

15 Filed DEC 5 - 1921 19 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11. 1921. to Dec 3rd 1921.
that I last saw her alive on Dec 3rd. 1921.
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) A. C. Heuer M. D.

12/3. 1921 (Address) 2600 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Dec. 6 1921

20 UNDERTAKER: Lilly & Zirkin.

ADDRESS: 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59107

CERTIFICATE OF DEATH.

D 59107

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Sydenham Hospital ST. [illegible] WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Evans.

(a) RESIDENCE. No. 3225 Fleet ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fayette Co. W. Va.

PARENTS

10 NAME OF FATHER Clarence Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carter Co Ky.

12 MAIDEN NAME OF MOTHER Leota Cantley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Clarence Evans
(Address) 3225 Fleet St.

15 DEC 5 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1921, to Dec 4, 1921, that I last saw him alive on Dec 4, 1921, and that death occurred, on the date stated above, at 2:45 p. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? culture (+)

(Signed) B. MacGowan M. D.

. 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Dec. 5 1921
20 UNDERTAKER Lilly & Zuke	ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59108 D 59108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital St. 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Black

(a) RESIDENCE. No. Chesterton Md St., Ward. Chesterton Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? 18 yrs. 7 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of — Herbert Black

6 DATE OF BIRTH (month, day, and year) April-24-1903

7 AGE — Years: 18 — Months: 7 — Days: 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chesterstown Md

PARENTS

10 NAME OF FATHER: Jeremiah Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Marie Deitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Mercy Hospital Records (Address) Baltimore.

15 Filed . 19 — Registrar — Burial [illegible]

DEC 5 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to Dec 3, 1921, that I last saw h[illegible] alive on Dec 3, 1921, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Operation for Cystic Right ovary and Appendix

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Peritonitis and Visceral Septicemia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of Nov 28 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Findings, Signs & Symptoms

(Signed) John C Eyster M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chesterlown Kent Co. Md — DATE OF BURIAL: Dec 5 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59109

CERTIFICATE OF DEATH.

120 D 59109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Beulah Villa Apartments ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Caspari

(a) RESIDENCE. No. Beulah Villa Apartments ST., 15 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs 1 mos. 19 ds. How long in U. S., if of foreign birth? 63 yrs 1 mos 19 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Oct-15-1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	19	

8 OCCUPATION OF DECEASED 068

(a) Trade, profession or particular kind of work Teacher Public Schools

(b) General nature of industry, business, or establishment in which employed (or employer) (Teachr. Westn. H. Schl)

(c) Name of employer City of Baltimore.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Caspari

11 BIRTHPLACE OF FATHER (city or town) Hanover
(State or country) Germany

12 MAIDEN NAME OF MOTHER Alwine Heinsius

13 BIRTHPLACE OF MOTHER (city or town) Hanover
(State or country) Germany

14 Informant (Dr. Wm. Caspari) brother,
(Address) 1603-Madison-Av., City.

15 Filed . 19
DEC 5 - 1921
[illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 1. to Dec 4 1921.
that I last saw her alive on Dec 4 1921.
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically & Laboratory &

(Signed) W. Caspari, M. D.

1921 (Address) 1603 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec-6-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Annie Henry

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 59110

CERTIFICATE OF DEATH.

64 D 59110

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 N Montford ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Heaney

(Residence in Baltimore: No. 1202 N Montford St.; 50 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, May (Month) ....., 1862 (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 600

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Bernard Gannon

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Clarke

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard Henry

(Address) 1202 N Montford Ave

15-

DEC 5 - 1921 BOARD OF HEALTH

Filed....., 191..... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Nov 27 1921, that I saw h[er] alive on Nov 1 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 4 yrs. mos. ds.

(Signed) Frederick L Haines M. D.

Dec 4., 1921 (Address) 1301 N Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Vincent's Cemetery — DATE OF BURIAL, Dec. 5, 1921

20-UNDERTAKER E. D. Fanning & Son — ADDRESS 1938 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59111

CERTIFICATE OF DEATH.

108 D 59111

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Daniel Dougherty

(a) RESIDENCE NO. 418 E. Eager ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Daniel Dougherty

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Cavanaugh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Records.
(Address)

15 Filed ... 19... ROBERT J. BRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1921, to Dec. 4, 1921, that I last saw him alive on Dec. 4, 1921, and that death occurred, on the date stated above, at 12:40 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Operation 1. Papilloma of Gall Bladder
2. Chronic Appendicitis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? Yes Date of Nov. 30, 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) Rose Zellman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Dec. 6 1921

20 UNDERTAKER E. J. Fanning Inc. 1938 E. Lafayette — ADDRESS

HAVE THESE DEFINITE SUPPLIES. ASCERTAIN EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Pks.

D 59112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of Am. Hosp. 24

CITY OF BALTIMORE: (No. 418 W. Lexington ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. A. Zang

(a) RESIDENCE. No. 1702 Johnson ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Zang.

6 DATE OF BIRTH (month, day, and year) Nov. 26 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O. Railroad

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Charles Zang.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sophia Zang (Address) 1702 Johnson St.

15 Filed . 19 Registrar

DEC 5 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30 . 1921 . to Dec. 1 . 1921, that I last saw h[illegible] alive on Dec. 1 . 1921, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs —

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart & Bright dis.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? 1702 Johnson St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical Symp-toms

(Signed) J. L. Tayanall . M. D.

. 19 (Address) 418 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer

DATE OF BURIAL 12/5 1921

20 UNDERTAKER Margaret E. Flynn

ADDRESS 1421 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 59113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 908 Ramsey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Husk

(a) RESIDENCE. No. 908 Ramsey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Bowen Husk

6 DATE OF BIRTH (month, day, and year): Aug 15th 1876

7 AGE — Years: 45. Months: 3 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman 186

(b) General nature of industry, business, or establishment in which employed (or employer): for City.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph F. Husk.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Julia Tibbals.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Julia Husk

(Address): 908 Ramsey St-

15 Filed DEC 5 - 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 21, to Dec 2, 19 21, that I last saw h[illegible] alive on Dec 1, 19 21, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd M. D.

Dec 5 1921 (Address) 65 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 5 1921
20 UNDERTAKER	ADDRESS
John Cowan & Son Per F.J. Cowan	908 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59114

CERTIFICATE OF DEATH.

151 D 59114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4722 Frederick St.; WARD) Gavans

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John, Baby Bernel

(Residence in Baltimore: No. Same St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED,~~ ~~WIDOWED,~~ OR ~~DIVORCED,~~ (Write the word.)

6-DATE OF BIRTH, 12 (Month) / 2 (Day), 1921 (Year).

7-AGE, 2 hours. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 4722-Baltimore

PARENTS.

10-NAME OF FATHER, John Bernel

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER — Ebey

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Bernel

(Address) 4722-Frederick

15-

Filed DEC 5 - 1921, 191.. ROBERT E. LAZZELL Registrar.

Burial ... Dist.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) / 2 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 12/2 1921, to 12/3 1921, that I saw h~~im~~ alive on 12/2/21 1921, and that death occurred, on the date stated above, at 1500 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Primary

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Stanley Corner M. D.

12/3, 1921 (Address) 1900 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Dec 5, 1921
20-UNDERTAKER. N. S. FINK	ADDRESS
FUNERAL DIRECTORS	
1835 W PRATT STREET	N. S. F.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59115

CERTIFICATE OF DEATH.

30 D 59115

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 652 W. Lombard ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Avron Charles Kleiman

(a) RESIDENCE NO. 652 W. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) May 12th, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child Dod

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Maryland

PARENTS

10 NAME OF FATHER Ben Kleiman

11 BIRTHPLACE OF FATHER (city or town) Balto., (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Parisen

13 BIRTHPLACE OF MOTHER (city or town) Balto., (State or country) Maryland

14 Informant Ben Kleiman

(Address) 652 W. Lombard

15 DEC 5 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17

I HEREBY CERTIFY, That I attended deceased from June, 1920, to Dec 4, 1921, that I last saw him alive on Dec 4, 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. 1 hour ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tbc bacilli in spinal fluid

(Signed) John Rubrich M. D.

Dec 4, 1921 (Address) 116 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	12-5 1921
20 UNDERTAKER Park Funl. 1411 E	ADDRESS Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59116

CERTIFICATE OF DEATH.

79 D 59116

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2302 McCulloh ST., 13 WARD)

2-FULL NAME Mrs Annie Lapsin

(a) RESIDENCE NO. 2302 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard Lapsin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	7[illegible]			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): [illegible] 1411 E. Baltimore St.

15 Filed DEC 5 - 1921 19 ROBERT J. FEATHER Registrar

Buried Dec 5 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1917 to Dec. 3rd 1921,

that I last saw her alive on Dec. 3rd 1921,

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Chronic bronchitis, Asthma,

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Eugene J Leopold, M. D.

, 19 (Address) 803 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12-5 1921
20 UNDERTAKER	ADDRESS
[illegible] Smith	1411 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Changed 28-1921

Baltimore, Md., Dec. 23, 1921.

I hereby certify that the age of Annie Lapin, who died on December 3rd, 1921, as set forth on the attached paper (76) is incorrect and should be 71 years.

Eugene J Kaporek

Subscribed and sworn to before me, this 23rd day of December, 1921.

Dorothy E. Perry
Notary Public.

D59116

R. EUGENE J. LEOPOLD
803 PARK AVENUE

CONSULTATION HOURS
3 TO 4 P. M.
AND BY APPOINTMENT

BALTIMORE, December 13th 1921

Dr C Hampson Jones,
Commissioner of Health,
Baltimore.

Dear Sir:

Through some error, I have entered the age of Mrs Anne Lapin, 2302 Mc Culloh St. who died December 3rd 1921 as being "76" years. The family tell me, and my record shows that 71 years is the correct age.

The family also inform me that the insurance companies are holding up the payment of their claims because of this discrepency. Might I ask that you department correct the age to 71 years?. Any charge resulting from this correction will be paid by me upon the receipt of notification.

Thanking you in advance for your cooperation in this matter,

Yours truly

Eugene J Leopold

Mr. Grove

BALTIMORE CITY HEALTH DEPARTMENT
DEC 14 1921

Clotilda Smith

D 59117 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 59117

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3604 Cedar ave St., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clotilda Smith

(Residence in Baltimore: No. 3604 Cedar ave St.; yrs., 2 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 30, 1921 (Month) (Day) (Year)

AGE yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

7-OCCUPATION (a) Trade, profession, or particular kind of work..... Child

(b) General nature of Industry, business, or establishment in which employed (or employer).....

8-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, Albert Smith

11-BIRTHPLACE OF FATHER (State or Country), W Va

12-MAIDEN NAME OF MOTHER, Myrtle Pomrey

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Smith

(Address) 3604 Cedar ave

15-

Filed DEC 5 - 1921 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank Conway M. D.

(Coroner) 1921 (Address) 5432 Reisterstown Rd

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden

DATE OF BURIAL, Dec 5, 1921

20-UNDERTAKER Chenowith & Son

ADDRESS Chestnut St

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, as this is very important. See instructions on back of certificate. PHYSICIANS should state the proper name, class and residence of each attendant of OCCUPATION

Insanition

Statement of Occupation.—Precise [illegible] of occupation is very important, so that [illegible] relative healthfulness of various pursuits can [illegible] known. The question applies to each and every [illegible]on, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59118

CERTIFICATE OF DEATH.

92 D 59118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Huntington Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose De Bella

(a) RESIDENCE. No. 3107 Huntington Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jos De Bella

6 DATE OF BIRTH (month, day, and year): Jan 4 1871

7 AGE: Years 50 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 007

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Anna J De Bella

(Address) 3107 Huntington Ave

15 Filed DEC 5 - 1921 19 ROBERT P. REA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 3, 1921, that I last saw her alive on Dec 3, 1921, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Richardson M. D.

, 19 (Address) 1124 N. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 6 1921

20 UNDERTAKER: Chenowith & Son ADDRESS: Chestnut Ave

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospt. ST.: 13 WARD)

170 D 59119

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nannie Butler

(a) RESIDENCE. No. 2144 Woodbury Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard W Butler

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 50 Months: 1 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (Wife)

(b) General nature of industry, business, or establishment in which employed (or employer): Paid for 7 100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md Smithsburg Washo Co

PARENTS

10 NAME OF FATHER: John C Frankle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md. Shmg

12 MAIDEN NAME OF MOTHER: Johanna Mitchel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Georgl Frock
(Address) 2144 Woodbery Ave

15 Filed . 19 ROBERT J. CARTER Registrar
DEC 5 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 19 21

17 I HEREBY CERTIFY, That I attended deceased from 11/24/21 . 19 . to 12/3/21 . 19 . that I last saw h~~e alive~~ on 12/3/21 . 19 . and that death occurred, on the date stated above, at 12 20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Infuse Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Insufficiency

(duratiun) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. Atkinson, M. D.

. 19 (Address) Md Gen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 5 19 21

20 UNDERTAKER: Ehenowith Son — ADDRESS: Chestnut Ave

NOTE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59120
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Battery Ave & York St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Larkins.(C)

(Residence in Baltimore: No. 930 S. Sharp St.

5 ------ St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, August 30th. 1873, 1
(Month) (Day) (Year)

7-AGE, 48 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer): 174

9-BIRTHPLACE. (State or Country). Georgia.

PARENTS.

10-NAME OF FATHER, Noah Larkins.(C)

11-BIRTHPLACE OF FATHER (State or Country). Georgia.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. Larkins.(C) wife.

(Address) 930 S. Sharp St.

15- DEC 5 - 1921 Filed ....., 191.... BOYLE & REESIDE Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2nd. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Dec 4th., 1921. (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ct

DATE OF BURIAL, DEC 5, 1921.

20-UNDERTAKER J. H. Brown & Son

ADDRESS 10 N. Montgomery

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59121

CERTIFICATE OF DEATH.

31 D 59121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Fountain St., WARD 11)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lothman

(a) RESIDENCE NO. 1114 Fountain St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Single~~

6 DATE OF BIRTH (month, day, and year) 11/18/1819

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	102	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co., Md

12 MAIDEN NAME OF MOTHER Fanny Sothern

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Fannie Johnson

(Address) 1114 Fountain Ave

15 Filed DEC 5 - 1921 Buried [illegible] Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/27, 1921, to 12/1, 1921, that I last saw her alive on 12/1, 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Obstruction of the bowels

(duration) yrs. 6 hrs mos. ds.

CONTRIBUTORY (Secondary) Probably T.B. Peritonitis (duration) yrs. mos. ?, ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. Lee Ellis, M. D.

, 19 (Address) 92 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	12/5, 1921
20 UNDERTAKER J. Lion Hall	ADDRESS 1741 D. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59122

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 59122

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Warren Ave ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Deved

(a) RESIDENCE. No. 901 Warren Ave ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George L Deved

6 DATE OF BIRTH (month, day, and year) Nov 25 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phillipsport (State or country) New York

PARENTS

10 NAME OF FATHER Rudolphus Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Anna Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs A L Lewis (Address) 30: Warren Ave

15 Filed DEC 5 - 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Dec 1st, 1921, that I last saw h[illegible] alive on Dec 1st, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Dec 4, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	DEC 5 1921 19
20 UNDERTAKER JOHN F. DENNY 716 LIGHT ST.	ADDRESS

CAUSE OF DEATH is plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1090 Bks.

D 59123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 59123

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Spriggs

(a) RESIDENCE. No. 1037 Gillis Court ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brookville, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rachel Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Date DEC 5 - 1921 [illegible] Registrar

[illegible] Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to Dec. 2nd, 1921, that I last saw her alive on Dec. 2nd, 1921, and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 1 mos. plus ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) Francis L. Balaghusen, M. D.

12-2-21 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M. Auburn — DATE OF BURIAL DEC 6 1921

20 UNDERTAKER Wm. H. Chase Sons — ADDRESS 1460 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1300 Bks.

D 59124

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

64 D 59124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 George St. St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Green

(a) RESIDENCE. No. 746 George St. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Hotel work

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER Michael Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs H Green
(Address) 528 W Lanvale St

15 Filed ....., 19.... Robert J. Cuddy Registrar
DEC 5 - 1921 Assistant Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to Dec-3, 1921, that I last saw him alive on Dec 2, 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy + Paralysis

(duration) 2 weeks

CONTRIBUTORY (Secondary) Dont Know

(duration) dont know yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H K Gounds M. D.

12-4-1924 (Address) 1170 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Prince George Co Md	DEC 6 1921
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1400 Pulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59125 | CERTIFICATE OF DEATH. | 150 | D 59125

1-PLACE OF DEATH | REGISTERED No. C

CITY OF BALTIMORE (No. 938 N. Stricker ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ralph Dorgan

(Residence in Baltimore: No. 938 N. Stricker st St.: yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
male	colored	single

6-DATE OF BIRTH, Dec. 2, 1921 (Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds. If LESS than 1 day, 7 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... none
(b) General nature of industry, business, or establishment in which employed (or employer) ... (Infant)

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. William T. Dorgan

11-BIRTHPLACE OF FATHER (State or Country). S. Carolina

12-MAIDEN NAME OF MOTHER. Effie Turner

13-BIRTHPLACE OF MOTHER (State or Country). N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. T. Dorgan

(Address) 938 N. Stricker St

15- FILED DEC 5 - 1921 BOYER & EBLUTER Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paten[illegible] foramen ovale

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessey M. D.
(Coroner)

Dec. 3, 1921. (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Dec. 6 1921
20-UNDERTAKER	**ADDRESS**
Sam'l V. Chase Co	1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 59126

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 59126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 2610 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Jablonska

(Residence in Baltimore: No. 2610 Hudson St, St.; yrs. 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	single

6-DATE OF BIRTH, Oct (Month) 17 (Day), 1921 (Year)

7-AGE, yrs. 1 mos. 16 ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER, Michael Jablonski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Milenko

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jablonski

(Address) 2610 Hudson St

15- Filed DEC 5 - 1921 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 3 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 2 1921, to Dec 3 1921, that I saw h er alive on Dec 3 1921, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Travis D Johnson M. D.

Dec 4, 1921. (Address) 2431 Fait Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus — DATE OF BURIAL, Dec 5, 1921

20-UNDERTAKER John M Weber — ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59127

CERTIFICATE OF DEATH.

19 D 59127

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Hillsdale ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael D Lyons

(a) RESIDENCE. No. 1329 Hillsdale ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Lyons

6 DATE OF BIRTH (month, day, and year) April 6 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer 1586

(b) General nature of industry, business, or establishment in which employed (or employer) Paley & St

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michl Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Beers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Lyons
(Address) 1329 Hillsdale St

15 Filed DEC 5 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 30 1921, to Dec 2 1921, that I last saw him alive on Dec 2 1921, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Hm. P. Geraghty, M. D.

19- (Address) 203 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 6 1921
20 UNDERTAKER Robt J Turner Jr	ADDRESS 1502 N Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59128

12 D 59128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 318 Wyman Ave ST.: 12 WARD)

2-FULL NAME Mary Anna Richard

(a) RESIDENCE NO. 318 Wyman Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs 6 mos da. How long in U. S., if of foreign birth? yrs mos da.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Christian Richard

6 DATE OF BIRTH (month, day, and year) June 12th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto: Maryland

PARENTS

10 NAME OF FATHER Charles McDonald

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Pickett

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mrs Engelhardt
(Address) 4504 Walther Ave Louisville

15 Filed DEC 5 - 1921 ROBERT E. LEAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

(6 DATE OF DEATH (month, day, and year) Dec 3, 1921

17 I HEREBY CERTIFY, *That I attended deceased from Nov 10, 1921, to Dec 3, 1921, that I last saw her alive on Dec 3, 1921, and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis, interstitial nephritis (chronic)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. Lee Wagner, M. D.

Dec 7, 1921 (Address) 1206 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	Dec. 6th 1921
20 UNDERTAKER Frank Leasch and Sons	ADDRESS Fullerton Md.

Information should be carefully supplied. Age, Color, Sex, Single, Married, Widowed or Divorced should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59129

CERTIFICATE OF DEATH.

50 D 59129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4429 Clifton ave ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin L. Junis

(a) RESIDENCE NO. 4429 Clifton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen J. Junis

6 DATE OF BIRTH (month, day, and year): Jan 27 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	71	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10 NAME OF FATHER: John O. Junis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Georgeanna Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Oliver L. Junis Hudson-Hills

15 DEC 5 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Dec 3, 1921, that I last saw h[illegible] alive on Dec 3, 1921, and that death occurred, on the date stated above, at 12-Noon m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis — diabetes.

myocarditis — chronic bronchitis

nephritis.

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) W. S. Tublett, M. D.

Dec 4 21 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Dec 5 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St

IMPORTANT: Should be carefully prepared. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59130

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Notre Dame of Md. Chas. St. Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Ignatia O'Connell

(a) RESIDENCE. No. Notre Dame of Md. Chas. St. Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 30, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Clonmel, Ireland

PARENTS

10 NAME OF FATHER: Bryan O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Clonmel Ireland

12 MAIDEN NAME OF MOTHER: Johanna Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: School Sisters of Notre Dame
(Address): Charles St Ave. Balto, Md.

15 Filed Dec 3 1921 DEC 5 1921 J C Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 1921

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to Dec 3, 1921, that I last saw h. alive on Dec 2, 1921, and that death occurred, on the date stated above, at 3:40 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis and Chronic Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones, M. D.

Dec 3, 1921 (Address) 706 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govenstown - Private	Dec 6 1921
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N Gay St

W1816

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Abt 60 or 70 yrs.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 59131

1-PLACE OF DEATH D 59131

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bell

(a) RESIDENCE. No. 216 Spring St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Elizabeth, New Jersey

PARENTS

10 NAME OF FATHER James Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER Ann McCove

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records, (Address) Municipal Hospital.

15 Filed DEC 5 - 1921 ROBERT F. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1921

17

I HEREBY CERTIFY, That I attended deceased from December 1, 1921, to December 2, 1921, that I last saw him alive on December 1, 1921, and that death occurred, on the date stated above, at 3:00 A. M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) / yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

12/2/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59132

D 59132

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Williams

(a) RESIDENCE. No. 707 W. Redwood st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Charles Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Rosie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Flordia

11 Informant Hospital Records

(Address) M. J. H.

15 Filed DEC 5 - 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1921, to Dec. 1, 1921, that I last saw him alive on Dec. 1, 1921, and that death occurred, on the date stated above, at 6.25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

5 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum X-ray

(Signed) Francis L. Dalaglesh M. D.

12-2-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner Health	ADDRESS DEC 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lois L. Buttner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59133

CERTIFICATE OF DEATH.

104 D 59133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Bell. ST.; 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis L. Buttner.

(a) RESIDENCE. NO. 1722 Bell. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1. 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 0/0

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edw. J. Buttner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Grazia Wolfe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co. Md.

14 Informant Grazia Buttner.
(Address) 1722 Bell

15 DEC 5 - 1921

[illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1. 1921, to Dec 4 1921, that I last saw her alive on Dec. 4. 1921, and that death occurred, on the date stated above, at 12.05 hours.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. H. Seabury, M. D.

12/5. 1921 (Address) 638 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Plane 4, Fred'k Co. Md. DATE OF BURIAL: Dec. 6 1921

20 UNDERTAKER: E. D. Fanning & Son ADDRESS: 1460 Battery Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59134

CERTIFICATE OF DEATH.

9 D 59134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Clark in Hill St. Mt. Washington Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Waldron

(a) RESIDENCE NO. Clark in Hill ST. " WARD Mt. Washington
(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced: (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 28 1911

7 AGE: Years 10 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Patrick Waldron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Waldron
(Address) 2nd Washington

15 Filed DEC 5 - 1921 Robert J. Reuter Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/3 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/27/18, 1921, to 12/3, 1921, that I last saw h[illegible] alive on 12/2, 1921, and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis Infectiosa

3 Weeks (duration)

CONTRIBUTORY (Secondary) Post Diphtheritic Paralysis (duration) yrs. mos. 3 Weeks

18 Where was disease contracted if not at place of death? Out of quarantine 3 weeks

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Henry F. Cassidy M. D.

(Address) Clark & Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Dec 6 1921

20 UNDERTAKER: Pohl & Schmitt

ADDRESS: W. Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Out of quarantine
Feb. 3 G.T.E.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 59135

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella McCauley

(a) RESIDENCE. No. 1204 John St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown 12/ 5/19 21

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed Robert P. Harrison, Registrar
5 - 1921 Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 3 1921

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1921, to December 3, 1921, that I last saw her alive on December 3, 1921, and that death occurred, on the date stated above, at 2:05 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds

CONTRIBUTORY (Secondary) Secondary anemia

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 6 1921
20 UNDERTAKER	ADDRESS
Wm Fleckner Sons	North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59136

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 William ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice J. Wingrave

(a) RESIDENCE NO. 706 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Feimal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harold S Wingrave

6 DATE OF BIRTH (month, day, and year): Jan 28 1870

7 AGE: Years 52 Months 10 Days 5 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Devine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catharine Carlton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Harold S Wingrave 706 Williams St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to Dec 3, 1921,

that I last saw h[illegible] alive on Dec 3, 1921

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fehlings

(Signed) J H Hyatt, M. D.

, 19 (Address) 302 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 6 19

20 UNDERTAKER: W J Tschudy — ADDRESS: Lemmon

5-1921

BE SURE THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

D 59137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 168

CITY OF BALTIMORE (No. 3204 Fordrick Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pasquale Palmerino

(Residence in Baltimore: No. 3204 Fordrick Ave. 9 - - - St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Apr 16, 1861 (Month) (Day) (Year)

7-AGE: 60 yrs. 7 mos. 17 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer): M J

9-BIRTHPLACE, (State or Country): Italy

PARENTS:

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (State or Country): do

12-MAIDEN NAME OF MOTHER: do

13-BIRTHPLACE OF MOTHER (State or Country): do.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adeline Palmerino

(Address) 103 N. Fremont St.

15-

Filed ....., 191.....

Registrar. Robert P. Harrison, Burial Permit Clerk.

5 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 3 - , 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxia (Gas)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Blake M. D. (Coroner.)

Dec 20, 1921. (Address) 1436 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec. 6, 1921.
20-UNDERTAKER	ADDRESS
Mr & Mrs J. W. Teufel & Son	801 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

gas poor, Dr pneumonia pulmonary

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59138

43

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 W. North Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Harris.

(a) RESIDENCE. NO. 2811 W. North Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Harris jr.

6 DATE OF BIRTH (month, day, and year) Sept 9- 1869

7 AGE 52 Years	Months 2	Days 25	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER M. Jolley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Mrs. Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

11 Informant John T. Harris
(Address)

15 Filed 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2 , 1920 , to Dec 3rd , 1921 , that I last saw h[illegible] alive on Dec 3rd , 1921 , and that death occurred, on the date stated above, at 2 P A m.

The CAUSE OF DEATH* was as follows:

Spinal metastasis.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of breast

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2911 W. North Ave

Did an operation precede death? yes Date of May 1917

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Conrad Bode , M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 1/6 1922

20 UNDERTAKER William Cook ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59139

CERTIFICATE OF DEATH.

D 59139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of the Poor (ST.) 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Martin.

(a) RESIDENCE. NO. Preston & Valley Sts., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Martin.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Cornelius Moylan

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary Ann Carroll.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sister Florence
(Address) Preston & Valley Sts.

15 Filed Dec 5 1921 Robert P. Harrison
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1921 to Dec 4 1921, that I last saw h Sr alive on Nov 27 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Influenza (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warren, M. D.

Dec 5, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Dec 6. 1921

20 UNDERTAKER ADDRESS

H. C. Windefeld 914 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Annie R. Price) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59140

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mary Land General Hospital 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L Price

(a) RESIDENCE. No. 2850 Woodbrook Ave ST.: WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 5/6 yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced.
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County, Md.

PARENTS

10 NAME OF FATHER John Henry Leyh.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Ann Davis

13 BIRTBPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant John E Price
(Address) 2850 Woodbrook Ave

15 Filed DEC 5 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1921, to Dec. 4, 1921, that I last saw h[illegible] alive on Dec 4. 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Annular Carcinoma of Large Intestine causing Intestinal Abstruction.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 2850 Woodbrook Ave.

Did an operation precede death? Yes Date of Nov. 28. 1921

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Whitehead, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sisters Cemetery Balt Co	Dec 6 1921
20 UNDERTAKER	ADDRESS
Josiah Leyh	1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H P. Co.—1000 Bks.

D 59141 ✓ D 59141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59141

CERTIFICATE OF DEATH.

186

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE (No. ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Francis Coniff.

(a) RESIDENCE. No. 2746 W. Fairmount Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER John E. Coniff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John Edward Coniff 2746 W. Fairmont Ave

15 Filed , 19 . , Registrar

C5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1921, to Dec 4, 1921, that I last saw him alive on Dec 4, 1921, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia due to foreign body in oesophagus. (Over)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2746 W. Fairmount Ave

Did an operation precede death? yes Date of Dec 3, 1921

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. X Ray

(Signed) W. S. Jones, M. D.

12/4, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Londen Park.	Dec 6 1921

20 UNDERTAKER ADDRESS

Josiah Dyer 1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This child got some foreign body in Oesophagus 4 mos ago. Was in Hospital 2 days Tracheotomy was done and attempt made to remove object through oesophagoscope. Operation not successfull as foreign body was found down well near stomach and probably had ulcerated in trachea

T. B. Jones M.D.

D 59142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59142

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 230 Falls Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Jones.

(Residence in Baltimore: No. 230 Falls Road St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	C.	—

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE About 5. yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER, Ehore. Jones.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Harris

(Address) 230 Falls Road

15- Filed ....., 191.... Registrar.

Robert P. Harrison, Clerk.

DEC 5 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) John Thomson M. D. (Coroner)

Dec 5 1921 (Address) 5032 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL DEC 5 1921

Par. Wm. C. [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No history of any infection fever

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59143

CERTIFICATE OF DEATH.

107 D 59143

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 302 Camel ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Roberts

(a) RESIDENCE. No. 302 Camel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhemina A Roberts

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 45 Years	Months —	Days —	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer) Selling Coal

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abram Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Wilhemina A Robert 30 Camden St

15 Filed 12/8, 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 16 , 19 21 , to Dec 2 , 19 21 .

that I last saw h— alive on Dec 2 , 19 21 .

and that death occurred, on the date stated above, at 6.40 a m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer V
Hemorrhage

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. (?) mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Stomach Contents

(Signed) Edw Short, M. D.

12/8, 1921 (Address) 1512 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	12/6/21

20 UNDERTAKER ADDRESS

Felix B. Pyle 1022 Mulberry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death), 29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant.

Duffey ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59144

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3126 Abell Ave. St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Duffey

(a) RESIDENCE. No. 3126 Abell Ave. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Duffey

6 DATE OF BIRTH (month, day, and year) Feb. 28" 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Nicholas Harden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mary F. Clark (Address) 3126 Abell Ave.

15 Filed Dec 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3" 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Dec 3 1921, that I last saw h alive on Dec 3 1921, and that death occurred, on the date stated above, at 10.30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Apoplexy)

(duration) yrs. mos. ds.

CONTRIBITORY (Secondary) Arteri Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claud Smith, M. D.

Dec 5 1921 (Address) 4202 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 6" 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59145

CERTIFICATE OF DEATH.

5 D 59145

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) | V (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Irvine

(a) RESIDENCE. No. 1626 St. Paul St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE: Years — Months — Days 6 months gestation. If LESS than 1 day, hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert C. Irvine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Olive D. Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant (Address) Robt. C. Irvine 1626 St. Paul St.

15 Filed . 19 DEC 6 - 1921 Register. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 21, to Dec 3, 19 21, that I last saw him alive on Dec 3, 19 21, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Premature Spontaneous Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity 6 months (duration) Gestation yrs. mos. 4 hrs ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Visible Evidence

(Signed) John L. Cowie, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	12/5 1921

20 UNDERTAKER Chas. P. Evans & Son ADDRESS 1180 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59146 — 91 — D 59146

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N. Patterson Park Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J: Henry Lauterbach.

(a) RESIDENCE. No. 709 N: Patterson Park ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Kistendorff

6 DATE OF BIRTH (month, day, and year) Jan 26 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot 086

(b) General nature of industry, business, or establishment in which employed (or employer) Tolchester boat

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

11 Informant Carrie Lauterbach

(Address) 709 N: Patterson Park ave

15 Filed DEC 6 - 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov-12, 1921, to Dec 2-, 1921, that I last saw h[illegible] alive on Dec 2-, 1921, and that death occurred, on the date stated above, at 4.15a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? "Clinical".

(Signed) E Heller Hennig, M. D.

12/6, 1921 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: Dec 7 1921

20 UNDERTAKER: J Kenwig & Co — ADDRESS: 2008 Eden

Spec.—8-24-14—M. & T.—2000 Bks.

Elliott Hodges

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59147

CERTIFICATE OF DEATH.

REGISTERED NO. D 59147

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 741 Pierce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elliott Hodges

(Residence in Baltimore: No. 741 Pierce St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Widower

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Faith healer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Harrison Hodges

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emily Jones

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Harrell

(Address) 923 Myrtle Ave

15-

Filed DEC 6 - 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1921, to Dec 4 1921, that I saw h[illegible] alive on Dec 3 1921, and that death occurred, on the date stated above, at 8 Am. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec. 5., 1921 (Address) 1202 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cemetery	Dec 7, 1921
20-UNDERTAKER	ADDRESS
John H Fordmin	142 N Fremont

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59148

CERTIFICATE OF DEATH.

92 D 59148

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Leadenhall ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stanley Brown

(a) RESIDENCE. No. 803 Leadenhall ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. 11 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Brown

6 DATE OF BIRTH (month, day, and year) Dec 20 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	11	12	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Bootblack 046

(b) General nature of industry, business, or establishment in which employed (or employer) Barber Shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md,

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md,

12 MAIDEN NAME OF MOTHER Charity Leatherbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cornelia Brown
(Address) 803 Leadenhall st

15 Filed DEC 6 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1921, to Dec 2, 1921, that I last saw him alive on Dec 2, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam,

(Signed) D. H. Carroll, M. D.

12/3/21 19 (Address) 1401 W. Hill st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 6 1921

20 UNDERTAKER John H. Toadvine

ADDRESS 142 Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59149

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 59149

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp ST. ..... WARD)

2-FULL NAME Jerome Kelly

(a) RESIDENCE. NO. N & C Hosp ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 14 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John W Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Hattie Moldin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hattie Kelly
(Address) Nursery childs Hospetel

15 DEC 6 - 1921 ROBERT I. GRAFTY, Registrar
Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5th 1921, to Dec 5th 1921, that I last saw him alive on Dec 5th 1921, and that death occurred, on the date stated above, at 11:10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Intoxication.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? ?

What test confirmed diagnosis?

(Signed) Joseph Hennigar M. D.

19 (Address) 1007 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 6 1921
20 UNDERTAKER George J Smith	ADDRESS 100 W Fayette St

N. B.—WRITE PLAINLY WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

(Original Missing)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 59149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Nursery & Childs Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Kelly

(a) RESIDENCE NO. Nursery & Childs Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant

(Address)

15

Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17

I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acidosis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Fenglas, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
London Park Cemetery

DATE OF BURIAL
19

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109

D 59150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida E. Bucher

(a) RESIDENCE. NO. 2121 Fulton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bucher

6 DATE OF BIRTH (month, day, and year) 4-27-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Mayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Bartlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL, (Address) Records

15 FILED DEC 6 - 1921 ROBERT A. CRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 3 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-25 , 1921 , to 12-3 , 1921 ,

that I last saw her alive on 12-3 , 1921 ,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

OVER

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? Yes Date of 11/29/21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Emil Holman , M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or An deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Dec 6 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Mad Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59151

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Chapel ST., W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christiana Jones

(a) RESIDENCE NO. 522 S. Chapel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry W. Jones

6 DATE OF BIRTH (month, day, and year) May 10. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER George Bloodgood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lydia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sallie Chappant (Address) 520 S. Chapel St

15 Filed DEC 6 - 1921 ROBERT I. KRAUTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1921, to Dec 4, 1921,

that I last saw h alive on Dec 4, 1921,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Vascular Disease

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J Wenlinger, M. D.

Dec 4, 1921 (Address) 422 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	Dec 8 1921
20 UNDERTAKER	ADDRESS
L. Sander Sons	2210 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59152

CERTIFICATE OF DEATH.

37 D 59152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Race ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Dillihay

(a) RESIDENCE. NO. 1023 Race ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/14/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	20	/

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Percy Dillihay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bertha Dillihay
(Address) 1023 Race Street

15 Filed DEC 6 - 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4/21

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 19 21, to Dec 4th, 19 21, that I last saw h[illegible] alive on Dec 4th, 19 21, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Syphilis (Secondary) from birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paternal unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gunn Bowley, M. D.

12/5/ 19 21 (Address) 908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mont Auburn	Dec 6 1921
20 UNDERTAKER	ADDRESS
John H Owens	578 Dolphin

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 59153

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Morrow Hospital

CITY OF BALTIMORE: (No. 1132 N. Mount ST. 15 WARD)

2-FULL NAME Loyd Parker

(a) RESIDENCE No. 839 Lorman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Parker

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Annie Parker

(Address) 839 Lorman St.

15 Filed 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-29-, 1921, to 12-5-, 1921,

that I last saw him alive on 12-4-, 1921,

and that death occurred, on the date stated above, at 7.40 a m.

The CAUSE OF DEATH* was as follows:

Syphilis - myelitis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) muscles Paralysis of respiratory (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Spinal fluid examination

(Signed) Howard T. Olsen M. D.

, 19 (Address) 1132 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: 12-7- 1921

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59154

CERTIFICATE OF DEATH.

28D 59154

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Parrish ST., 19 WARD)

2-FULL NAME Mary Hardy

(a) RESIDENCE NO. 915 Parrish ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Leonard Hardy

6 DATE OF BIRTH (month, day, and year) Mar 11 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	8	22	

8 OCCUPATION OF DECEASED 041

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Day work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nathaniel Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cabarrus Co Md

12 MAIDEN NAME OF MOTHER Alice Harrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cabarrus Co Md

14 Informant Leonard Hardy
(Address) 915 Parrish St

15 Filed DEC 6 - 1921 ROBERT J. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1921, to Dec 3, 1921, that I last saw her alive on Dec 3, 1921, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Intercurrent of Lungs

(duration) yrs. 6 mos ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) E. William Frey M. D.

12/5, 1921 (Address) 1938 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn	DEC 7 - 1921 19
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 59155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2928 Westwood ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin M. Forrester

(a) RESIDENCE NO. 2928 Westwood ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Forrester

6 DATE OF BIRTH (month, day, and year) Dec 23 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	61	11	11	

8 OCCUPATION OF DECEASED 073

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) Baggage Master

(c) Name of employer B. & O. R. R. Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Allen E. Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline K. Orick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Caroline R. Forrester

(Address) 2418 St. Paul St.

15 Filed DEC 6 - 1921 Registrar John Outtchell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1921, to Dec 4th, 1921, that I last saw him alive on Dec 4th, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. L. Dickson, M. D.

, 19 (Address) 3055 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 6 1921

20 UNDERTAKER ADDRESS

John Outtchell 1201 N. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 ✓

D 59156

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3108 Clifton Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert S. Williams

(Residence in Baltimore: No. 3108 Clifton Ave St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH: June 10, 1876 (Month) (Day) (Year)

7-AGE: 45 yrs. 5 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manager
(b) General nature of industry, business, or establishment in which employed (or employer): Rubber Co.

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Robert H. Williams

11-BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Mary P. Sanderson

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roger B. Williams

(Address) 1607 Park Ave.

15-

Filed ..... 191.....

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 5, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gas inhalation (Illuminating)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Dec 15, 1921 (Address) 2802 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec. 8th 1921

20-UNDERTAKER: Hartig Fahey & Son

ADDRESS: 1827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T—1500 Bks.

D 59157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 59157

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Parish ST., 16 WARD)

2-FULL NAME Josephine Coston

(a) RESIDENCE No. 1212 Parish ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) ~~WIFE~~ of Simms Coston

6 DATE OF BIRTH (month, day, and year) Apr 14/81

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer Day work

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Henrietta Mieb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rosie Johnson
(Address) 916 Parrish St

15 Filed DEC 6 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1921, to Dec 2, 1921, that I last saw her alive on Dec 2, 1921, and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

0 V 60

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

Dec 3, 1921 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cemetery	Dec 6 1921

20 UNDERTAKER Edward Ringgold ADDRESS 1705 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59158

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1036 N. Saratoga St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Attey

(Residence in Baltimore: No. 1036 N. Saratoga St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day) 1870 (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Henson

(Address) 1036 N. Saratoga St.

15- DEC 6 - 1921

Filed ..... 191.. ROBERT B. KNAUER Registrar.

Burial Permit [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 1 ds.

(Signed) H. C. Yates M. D.

(Address) 1743 Nat'l Bank Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec. 6, 1921

20-UNDERTAKER Samuel Hensley ADDRESS 1520 Bolton

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59159 CERTIFICATE OF DEATH. 151 D 59159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Rating ST.: 4 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Roberts

(a) RESIDENCE. NO. 616 Rating. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Clarence Robb

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Centrille
(State or country) Maryland

14 Informant
(Address)

15 Filed DEC 6 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1921, to Nov. 30, 1921, that I last saw h~~im~~ alive on Nov. 30, 19.., and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. J. Cronin, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

21 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
University of Maryland	, 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59160

D 59160 CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucian Green

(a) RESIDENCE. No. 768 George st. ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook D21

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Frank Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) California

12 MAIDEN NAME OF MOTHER Mary Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) California

14 Informant Hospital Records
(Address) M. T. H.

DEC 6 1921

ROBERT A. REUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1921, to Dec. 2, 1921, that I last saw him alive on Dec. 2, 1921, and that death occurred, on the date stated above, at 8.5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum X-ray

(Signed) Francis L. Dadaglass, M. D.

12-3-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS Commissioner Health. DEC 6 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59161 ✓ 43 D 59161

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Church Home + Infirmary

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. N. Broadway ST.: (Feb WARD)

2-FULL NAME Mrs Corinne Bruce Elliott

(a) RESIDENCE. No..... Albion Hotel ST.. 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 40 yrs. 7 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Judge Thos. Ireland Elliott

6 DATE OF BIRTH (month, day, and year) Feby-16-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Chestertown Maryland

PARENTS

10 NAME OF FATHER Hanson K. Vickers

11 BIRTHPLACE OF FATHER (city or town) Chestertown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane B. Y. Stemwell

13 BIRTHPLACE OF MOTHER (city or town) Chaptico (State or country) St. Mary's Co. Md.

14 Informant Mrs S. T. Manning (sister)
(Address) 6-E-Read Street

15 Filed ..... 19 APR - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 1921, to Dec 5 1921, that I last saw h.er alive on Dec 5 1921, and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (scirrhus) of breast left with metastasis to pleura + bones of thorax

(duration) 3 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy with effusion left. (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 31, 1918

Was there an autopsy? No

What test confirmed diagnosis? Gallstones Section

(Signed) H. W. Noble, M. D.

, 19 (Address) Church Home Infy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Dec 7th 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59162

CERTIFICATE OF DEATH.

151

D 59162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Braddish Ave ST., 15 WARD)

2-FULL NAME George Howard Berger.

(a) RESIDENCE NO. 1817 Braddish Ave ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 19-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
		2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman Berger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Agnes Helmot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Herman Berger
(Address) 1817 Braddish Ave

15 Filed DEC 6 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1921, to Dec 5, 1921, that I last saw him alive on Dec 4, 1921, and that death occurred, on the date stated above, at 12-10 p. m.

The CAUSE OF DEATH* was as follows:

Insanity

(duration) yrs. 2 mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac (Stenosis)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George C. Shannon, M. D.

12/5 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Dec 7 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Northern

Spec.—1-10-21—M&T—1500 Bks.

D 59163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 59163

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 - East 27th ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora A. Bausler

(a) RESIDENCE NO. 610 - East 27th ST., WARD 9.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Edward B. Bausler

6 DATE OF BIRTH (month, day, and year) Oct 30-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 107

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John T. Speight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jane Conby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Information Edward B Bausler
(Address) 610 E. 27th

15 Filed DEC 6 1921 ROBERT J. BRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1921, to Dec. 3, 1921, that I last saw h[illegible] alive on Dec. 2/21 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion Syncope

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Tobies Dorsalis

(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No usual symptoms in such cases.

What test confirmed diagnosis?

(Signed) William J. Pillsbury, M. D.

, 19 (Address) 415 Cedarcroft Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 12/6 1921

20 UNDERTAKER Mclean Cook — ADDRESS Govans Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lutic.

Spec.-1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59164

CERTIFICATE OF DEATH.

D 59164

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2839 Woodbrook Ave WARD 23)

2-FULL NAME Annie M McGeehan

(a) RESIDENCE No. 2839 Woodbrook Ave WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Widow of Edward J McGeehan

6 DATE OF BIRTH (month, day, and year): March 5-1849

7 AGE: Years 72 | Months | Days | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs E K Coyle

(Address): 2839 Woodbrook Ave

15 Filed DEC 8 - 1921 Registrar

K Gorsuch Saratoga

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 20 1921 to Dec 5 1921.

that I last saw he alive on Dec 4 1921

and that death occurred, on the date stated above, at 8 35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Arter Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) K K Gorsuch M. D.

(Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec 8 1921

20 UNDERTAKER: William Cook Sons & Natta

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59165 ✓ D 59165

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 602 Spring Hill Terrace ST.; 27 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Louise Miller

(Residence in Baltimore: No. 602 Spring Hill Terrace St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH. June 30th, 1839
(Month) (Day) (Year)

7-AGE, 82 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Alexander Zachary

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mildred Shackelford

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L. Miller

(Address) 1714 E. Lafayette Ave

15- DEC 6 - 1921 ROBERT P. FOSTER

Filed....., 191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26 1921, to Dec 4 1921, that I saw her alive on Dec 4 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema,

(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis, Chronic Nephritis

(Duration)....yrs....mos....ds.

(Signed) Irving Miller M. D.

Dec. 5, 1921 (Address) 108 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Dec 7, 1921

20-UNDERTAKER John B. Spencer

ADDRESS 1325 N. Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Gierczak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59166

CERTIFICATE OF DEATH.

81

D 59166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 S Wolfe ST., V WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Gierczak

(a) RESIDENCE NO. 513 S Wolfe ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Gierczak

6 DATE OF BIRTH (month, day, and year) Nov 30 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....—

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER —— Rynazewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Jos. Gierczak 513 S Wolfe

15 Filed DEC 6 - 1921 ROBERT A KEATLEY Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1921, to Dec 5, 1921, that I last saw her alive on Dec 2, 1921, and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? General Physical Condition

(Signed) G C Eades, M. D.

19 (Address) 1436 Vera

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 7 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationery fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

Macey W. Morris

D 59167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59167

CERTIFICATE OF DEATH.

7

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Jefferson ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Macy W Morris

(a) RESIDENCE. No. 2204 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Israel Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Blanche Brodie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Israel Morris
(Address) 2204 Jefferson st

15 Filed DEC 6 - 1921 . 19 ROBERT J. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2d, 1921, to Dec. 6, 1921, that I last saw her alive on Dec. 6d, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Taylor, M. D.

12/6, 1921 (Address) 210 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	Dec 1921
20 UNDERTAKER: M. Levinson	ADDRESS 1129 E Balto St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 59168

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Abissinian

(a) RESIDENCE NO. 1807 N Payson ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Daniel Wiseman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Rutkotsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): S. Lewis 1411 E Baltimore

15 Filed DEC 6 - 1921 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 19.., to Dec 5, 19.., that I last saw h.. alive on Dec 5, 19.., and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL: 12/6/21

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not malignant

Polypus of Cervix Uteri

Stock—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59169

CERTIFICATE OF DEATH.

30 D 59169

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: / WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Baranowska

(a) RESIDENCE NO. 503 N. Potomac ST., / WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-25-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Paul Simon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Stella Baranowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant JOHNS HOPKINS H. SPITAL (Address) Baltimore

15 Filed 6-1921 Robert F. Harrison, Burial Permit Clerk. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-2, 1921, to 12-5, 1921, that I last saw h[illegible] alive on 12-5, 1921, and that death occurred, on the date stated above, at 8[illegible] m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis —

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar Puncture

(Signed) Horace G. Stuart, M. D.

12/6, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Dec 6 1921
20 UNDERTAKER	ADDRESS
Stephen J Falkowski	1000 E Fayette

C 6-1921

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59170

CERTIFICATE OF DEATH.

K 91-089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery r Child Hosp ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Raymond Colson

(a) RESIDENCE. NO. N. & C. Hosp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Feb~~ ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 9	!		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Howard Co; Md.

PARENTS

10 NAME OF FATHER Geo. Colson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?Md

12 MAIDEN NAME OF MOTHER Mattie Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?Md

14 Informant Mrs Mattie Foster
(Address) [illegible]

15 Filed DEC 6 1921, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1921, to Dec 5th 1921, that I last saw him alive on Dec 5th 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

over

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J Kenigton, M. D.

. 19 (Address) 100 E Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Vault	Dec 7 1921
20 UNDERTAKER E H B Hall	ADDRESS 1158 West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1328 Reynolds St. ST. 21st WARD) 104

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amy F. DeReuse.

(Residence in Baltimore: No. 1328 Reynolds St. St.: yrs., 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, October 25th. 1921., 1
(Month) (Day) (Year)

7-AGE, ----yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. (00)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Jack DeReuse.

11-BIRTHPLACE OF FATHER (State or Country). Holland.

12-MAIDEN NAME OF MOTHER Catherine Leinweber.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Garratt. (mother)

(Address) 1328 Reynolds St.

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

Burial Permit Clerk.

26-1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. Reinhardt M. D.
(Coroner)

Dec 6th 191.21 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Cross Cem. DATE OF BURIAL, 12-6, 19.21

20-UNDERTAKER E. & J. Staub ADDRESS 115 E. Read St.

N.B.—Every item of information blanks of certain kinds may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59172

D 59172

CERTIFICATE OF DEATH.

H V

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1413 Mt Royal Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine LaPorterie

(a) RESIDENCE. NO. 1413 Mt- Royal Ave. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred alma 35 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christopher Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ernestin Weisberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Adam Stein
(Address) 1413 Mt-Royal-Ave

15 [illegible] 1921 Robert P. Harris,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 12th 1921 to Dec 6 1921, that I last saw her alive on Dec 6 6-30 PM 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pelvic Carcinoma

OVER

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage of the Bowels (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? There was none necessary W Marchant, M. D.
(Signed)
, 19 (Address) 1818 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec 7 1921
20 UNDERTAKER Jos Jaerdens + Son	ADDRESS 217 S. Paca st.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 6 - 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Annie Marchant
1818 Dalton st,
Phila
Mch 25 98
Probably originated in ovary or uterus.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59173 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59173

CERTIFICATE OF DEATH.

REGISTERED NO. 92-076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank D. Duncan Jr.

(a) RESIDENCE. No. Lutherville ST., WARD. Lutherville Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 3 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lutherville Md.

PARENTS

10 NAME OF FATHER John D. C. Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cockeysville Md. Md.

12 MAIDEN NAME OF MOTHER Marguerate Coy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lutherville, Md Md.

14 Informant (Address) John D. C. Duncan. Lutherville Md

15 Filed ..., 19.. Robert P. Harrison, Registrar

6-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 5 1921

17 I HEREBY CERTIFY, That I attended deceased from 12 - 4, 1921, to 12 - 5, 1921, that I last saw h/M alive on 12 - 5, 1921, and that death occurred, on the date stated above, at 8-40 p. m.

The CAUSE OF DEATH* was as follows: OVER

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bi Lateral Otitis Media. Septicaemia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 12-4-21

Was there an autopsy? no

What test confirmed diagnosis? exam.

(Signed) F. A. Holden, M. D.

19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Cemetery Towson	12/7 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had chickenpox about 2 weeks prior but that condition had cleared. Operation for punctured ear drum. No history of any other infection

(Frederick Schneider)

Spec.—1-10-21—M&T—1500 Bks.

D 59174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59174

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 513 N Arlington ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredrick Schneider

(a) RESIDENCE NO. 513 N Arlington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie F Schneider

6 DATE OF BIRTH (month, day, and year) Aug 14 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frances Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie F Schneider

(Address) 513 Arlington ave

15 Dec 6 1921 Robt. P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1921, to Dec 5, 1921, that I last saw him alive on Dec 5, 1921, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lumpkin, M. D.

(Address) 826 N. Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 8 1921
20 UNDERTAKER	ADDRESS
Wm Rudolph Sons	N. Y. Pa.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59175

CERTIFICATE OF DEATH.

43 D 59175

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 20 w Mt Royal Av ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Blanche Browning

(a) RESIDENCE. NO. 20 w Mt Royal Av ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar B. Browning

6 DATE OF BIRTH (month, day, and year) Sept 2. 1872

7 AGE	49 Years	3 Months	2 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 037

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER Zachariah Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Zylpha Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Edgar B. Browning
(Address) 20 w Mt Royal Av

15 Filed 19 Robert P. Harrison,
Burial Permit Clerk. Registrar

6-1071

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 5 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1920, to Dec 5 1921, that I last saw her alive on Dec 4 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast —

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchitis Metastasis —

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of March 1921

Was there an autopsy? no —

What test confirmed diagnosis? Examination —

(Signed) Chas Hammond — M. D

DEC 5. 1921 (Address) 1327 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec 7 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59176 D 59176

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Rosseter ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine B. Goessman -

(a) RESIDENCE. No. 530 Rosseter ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	widow

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 17, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~89~~	89	1 -	22 -	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Mrs Geo F Haupt
(Address) 530 Rosseter ave

15 Filed 6-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4- 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov- 26, 1924, to Dec 4, 1924, that I last saw her alive on Dec 3, 1924, and that death occurred, on the date stated above, at 5-10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy'

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H K Gorsuch, M. D.

12-5-1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	12/7/24
20 UNDERTAKER	ADDRESS
Geo A Farley	Fulton & Fayette st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59177

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1104 Brewer ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Williams

(a) RESIDENCE. No. 1104 Brewer ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Massel Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Massel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Shord Md.

14 Informant Sarah Massel.

(Address) 1104 Brewer St.

15 [illegible] 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1921, to Dec 4, 1921, that I last saw h[illegible] alive on Dec 4, 1921, and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Frank B Bragunier M. D.

12/6, 1921 (Address) 1006 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Dec 7th 1921
20 UNDERTAKER	ADDRESS
[illegible]	1725 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59178

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59178

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1948 Whitx St. St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levi Woods

(Residence in Baltimore: No. 1948 Whitx St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Widower

6-DATE OF BIRTH, Aug. 2, 1839
(Month) (Day) (Year)

7-AGE, 82 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Mahony

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irving Woods

(Address) 2 Woodley Place

15- Filed DEC 6 1921, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Dec. 6 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pandon Park	Dec. 7, 1921
20-UNDERTAKER George J. Smith	ADDRESS 1000 N. Fayette St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59179

CERTIFICATE OF DEATH.

108

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U. P. D. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Larkin Robertson

(Residence in Baltimore: No. 1001 Harlem Ave, St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH. Sept. 1, 1915 (Month) (Day) (Year)

7-AGE. 6 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (child)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER. Thos. Robertson

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Bertha Thiede

13-BIRTHPLACE OF MOTHER (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Robertson

(Address) 1001 Harlem ave

15- Dec 6 1921 Robert P. Harrison, 191 Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 6, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(Duration) yrs. mos. 3 ds.

(Signed) J. C. Hemmeter M. D. (Coroner)

Dec. 6, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1001 Harlem Ave

Former or usual residence same,

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	12-8 1921
20-UNDERTAKER	ADDRESS
H. C. Blanning & Son	517 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 N. Bond ST.; 8 WARD)

REGISTERED NO. D 59180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pratt.

(a) RESIDENCE. NO. 1428 N Bond ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or 3 min.

over

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Benjamin H Pratt.

11 BIRTHPLACE OF FATHER (city or town) St Marys Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Corbett

13 BIRTHPLACE OF MOTHER (city or town) Hartford Md
(State or country)

14 Informant Benj H Pratt
(Address) 1428 N. Bond St

15 [illegible] 19 [illegible]

DEC 5 1921
1921
Registrar
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1921, to Dec 5th, 1921, that I last saw h alive on Dec 5th, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Dec 5 1921

20 UNDERTAKER: Robt J Turner

ADDRESS: 1402 N Gay

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Physician state child lived 5 min.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59181

CERTIFICATE OF DEATH.

D 59181

1-PLACE OF DEATH
CITY OF BALTIMORE: No. Mercy Hospital St.: W. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jules Strauss

(a) RESIDENCE. No. Southern Hotel St. Balto Md Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1858

7 AGE: Years 63 Months - Days 13
If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Bernard Stern
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Rachel Meyers
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records
(Address)

15 DEC 7 - 1921 [illegible] Registrar [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921, to Dec 6, 1921, that I last saw her alive on Dec 6, 1921 and that death occurred, on the date stated above, at 6:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis 3 months
Broncho-Pneumonia 2 wks
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs 6 hrs.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) John H Eshom, M. D.

(Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Dec 8 1921
20 UNDERTAKER	ADDRESS
Harry Sondheim	1818 W. Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59182

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospl ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlie Wilson

(a) RESIDENCE. NO. 923 Morris Av ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~41~~ yrs 52 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, ~~Widowed~~, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years ~~41~~ 52 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumbers helper

(b) General nature of industry, business, or establishment in which employed (or employer): Dr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Pleasant Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Lucynda Brown (aunt) 571 Orchard St

15 Filed DEC 7 1921 . 19 ROBERT I. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/4/21

17 I HEREBY CERTIFY, That I attended deceased from 11/29/21. 19 . to 12/4/21 19 .

that I last saw him alive on 12/4/21. 19 .

and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Cardiac dilation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No clinical findings.

What test confirmed diagnosis?

(Signed) J. A. Compton M. D.

. 19 (Address) Md Gen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: Dec 8 21

20 UNDERTAKER: David Carter

ADDRESS 916 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59183

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Calvin Ave. ST.: WARD 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Earl Younger

(a) RESIDENCE. NO. 421 Calvin Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 27th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William E. Younger

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Bessie C. Cox

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Julia Grace Cox
(Address) 421 Calvin Ave.

15 Filed DEC 7 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1921, to Dec. 6, 1921, that I last saw him alive on Dec. 4, 1921, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency (DW)

(duration) yrs. mos. 5 hrs.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Machin, M. D.

Dec. 6, 1921 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL Dec 8 1921

20 UNDERTAKER Jos B Cook — ADDRESS 1003 N Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonfection fricad

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 59184

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Guilford Ave. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Smith

(a) RESIDENCE. No. 3206 Guilford Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11" 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Christian J. Smith Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Weinberg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Ella L. Smith
(Address) 3206 Guilford Ave.

15 Filed DEC 7 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4" 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to Dec 4, 1921, that I last saw h m alive on Dec 4, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Apoplexy & Uremia.
Contributory

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Thompson M. D.

Dec 6, 1921 (Address) 1211 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Dec 7 1921
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 59185

CERTIFICATE OF DEATH.

40 D 59185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2129 Linden Avenue ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldie Radetzky

(a) RESIDENCE NO. 2129 Linden Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Radetzky

6 DATE OF BIRTH (month, day, and year) Unknown 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER William Radetzky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Zelda Petasky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Radetzky

(Address) 2129 Linden Avenue

15 Filed DEC 7 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1921, to Dec 6, 1921.

that I last saw her alive on Dec 6, 1921.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

about (duration) yrs. 7 mos - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray exam.

(Signed) Theodore H Robison, M. D.

(Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Road	12- 7 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto

IMPORTANT—Should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59186

CERTIFICATE OF DEATH.

174 D 59186

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Baptist Hospital St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John D. Spann

(Residence in Baltimore: No. 3019 Pulaski St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb (Month) 1 (Day), 1898 (Year)

7-AGE, 23 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundry-
(b) General nature of industry, business, or establishment in which employed (or employer) man

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John A. Spann

11-BIRTHPLACE OF FATHER (State or Country), Baltimore "

12-MAIDEN NAME OF MOTHER Sophia Myers

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Spann

(Address) 3019 Pulaski ave

15-

Filed DEC 7 1921, 191.. Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Acute Conjt
in dyspnea mechanical

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Hall Smelley M. D.
(Coroner.)

12-6, 191.. (Address) 2385 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel — DATE OF BURIAL, Dec 8, 19..

20-UNDERTAKER Zurhorst & Winkler — ADDRESS 1573 Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 59187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59187

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 E. Eager ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Gorman

(a) RESIDENCE No. 1732 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Charles B. Gorman

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	64	2	17	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Seuft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Grebner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Kunnath

(Address) 1732 E. Eager

15 Filed DEC 7 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to Dec 6, 1921.

that I last saw h[illegible] alive on Dec 6, 1921.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Education

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 109 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 9 1921
20 UNDERTAKER Burkhart Pirkler E. J. Z	ADDRESS 1739 Eager

BEFORE filling in Certificate, see that AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-59188 5-1565

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓091

CERTIFICATE OF DEATH. K 40 D 59138

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No.) ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfonso Mugica

(a) RESIDENCE. No. Mexico City, Mexico ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? about 1 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine

6 DATE OF BIRTH (month, day, and year) 1-31-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mexico City Mexico

PARENTS

10 NAME OF FATHER Antonio Mugica

11 BIRTHPLACE OF FATHER (city or town) (State or country) Puebla, Mex

12 MAIDEN NAME OF MOTHER Carmen Rodriguez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mexico City Mexico

14 Informant JOHNS HOPKINS HOSPITAL, (Address) Baltimore

15 Filed DEC 7 - 1921 19 ROBERT I. [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-6 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-25, 1921, to 12-6, 1921, that I last saw him alive on 12-6, 1921, and that death occurred, on the date stated above, at 12.40 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach 2 years.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (broncho) 3 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Dec 3 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil T Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mexico City, Mexico — DATE OF BURIAL: 12/7 1921

20 UNDERTAKER: Henry W. Means & Son — ADDRESS: 805 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59189

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 N. Charles St. ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Burke

(Residence in Baltimore: No. 1912 N. Charles St. St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 28 (Day), 1858 (Year)

7-AGE, 63 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Cecil Co Md

PARENTS.

10-NAME OF FATHER, Chas. Troy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Murphy

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Peabody Burke

(Address) 1912 N. Charles St.

15-

Filed ..... 191.. Registrar.

DEC 7 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1921, to Dec. 6th 1921, that I saw her alive on Dec. 5th 2 P.M. 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus Interstitial
(Colon)
(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Asthma & Bronchitis
(Duration) yrs. mos. 3d ds.

(Signed) Wilmer Brinton M. D.

Dec 7th, 1921 (Address) 1211 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount C. | DATE OF BURIAL, Dec 9, 1921

20-UNDERTAKER H. S. Marshall | ADDRESS 1390 Park Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59190

CERTIFICATE OF DEATH.

170 D 59190

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2103 E Eager St ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonia A Hauck

(a) RESIDENCE NO. 2103 E Eager St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Hauck

6 DATE OF BIRTH (month, day, and year) June.6.1900.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home 131
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Frank Savoik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Don't Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Charles Hauck
(Address) 2103 E Eager St

15 DEC 7 - 1921 Registrar

Bur. Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 6, 1921, that I last saw h alive on Dec 5 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchopneumonia
Nephritis

(duration) yrs. 13 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rosenau, M. D.
(Address) 801 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 8 19
20 UNDERTAKER	ADDRESS
John H[illegible]rwig & Co	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59191

CERTIFICATE OF DEATH.

19 D 59191

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Mulliken ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hamilton

(a) RESIDENCE. No. 1427 Mulliken ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country) born in Balt City

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) md
(State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country) Unknown

14 Informant Mrs Mary Hamilton Wife
(Address) 1427 Mulliken St City

15 Filed DEC 7 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to Dec 5, 1921, that I last saw h.. alive on Dec 4, 1921, and that death occurred, on the date stated above, at 2 45 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) J. Edward Dicken, M. D.

12-6 1921 (Address) 1612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Dec 7 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59192

CERTIFICATE OF DEATH.

17 D 59192

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. Johns Hopkins Hospital St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belle Roy

(a) RESIDENCE. No. 1353 Carroll St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037 Work

(b) General nature of industry, business, or establishment in which employed (or employer) Houre Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Balt City Md

PARENTS

10 NAME OF FATHER George Mathus

11 BIRTHPLACE OF FATHER (city or town) (State or country) E Shore Md

12 MAIDEN NAME OF MOTHER Verna Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed , 19 Registrar

DEC 7 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-3 , 1921, to 12-5 , 1921, that I last saw h[illegible] alive on 12-5 , 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Myocardial failure, supervening upon myocardial insufficiency

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Edwin Cowles Andrus , M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 8 1921
20 UNDERTAKER	ADDRESS
Mrs Rokers-A Elliott	1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59193

CERTIFICATE OF DEATH.

64 D 59193

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 E.Fairmount Ave. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Elizabeth Baxter Binnie

(a) RESIDENCE. No. 1807 E.Fairmount Ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed-

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Binnie

6 DATE OF BIRTH (month, day, and year) May ?-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William T.Moore

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mass

12 MAIDEN NAME OF MOTHER Ann Mahole

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Binnie (Daughter)
(Address)

15 Filed , 19
1921 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.5.1921 19

17 I HEREBY CERTIFY, That I attended deceased from Oct-7-, 1921, to Dec-6-, 1921, that I last saw her alive on Dec-5-, 1921, and that death occurred, on the date stated above, at 10:40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Old age & Nervous Debility

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William H. Johnson, M. D.

12/7. 1921 (Address) 2016 Guilford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec.8 1921
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59194

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S. Mount ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Webster Laumann

(a) RESIDENCE. No. 211 S. Mount ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Sept 18 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bridge Carpenter and watchman

(b) General nature of industry, business, or establishment in which employed (or employer): watchman

(c) Name of employer: H. O Finn

9 BIRTHPLACE (city or town) (State or country): Tellow Town Co Md

PARENTS

10 NAME OF FATHER: Adolph Laumann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Ann Rush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Martha Laumann
(Address): 211 S. Mount.

15 Filed 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/5/21 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 19 21, to Dec 4, 19 21,

that I last saw him alive on Dec 4, 19 21,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hewitt, M. D.

19 (Address) 1703 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec. 8, 1921

20 UNDERTAKER: Easton Sons — ADDRESS: Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59195

CERTIFICATE OF DEATH.

D 59195

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 W. West St. WARD 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Brown

(a) RESIDENCE. No. 524 W. West St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX W

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Brown

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Pullman Co.

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Brown

(Address) 524 W. West St

15 Filed DEC 8 1921 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/27/ 1921 to 12/5/ 1921

that I last saw him alive on 12/4/ 1921

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) about 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J. Turner Brooks, M. D.

12/6/ 1921 (Address) 908 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ralph Wlf. Emmanuel Co. Md	Dec 9 1921
20 UNDERTAKER John H. Woodall	ADDRESS 142 Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59196

CERTIFICATE OF DEATH.

92

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 165 W. Hamburg ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Hill

(a) RESIDENCE. No 165 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, Widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Deshields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annie Hill

(Address) 165 W Hamburg

Filed DEC 8 1921 ROBERT E LEDDEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1921, to Dec 6, 1921, that I last saw he alive on Dec 6, 1921, and that death occurred, on the date stated above, at 6 45 PM.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs 1 mos ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs 1 mos ds.

18 Where was disease contracted if not at place of death? 165 W. Hamburg

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C H Fischer M. D.

Dec 7, 1921 (Address) 114 S Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 10 1921
20 UNDERTAKER	ADDRESS
John H. Toadvine	1412 Ursell St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. Co.—1000 Blks.

D 59197 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59197

152396

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Allen

(a) RESIDENCE. No. 1125 E 20th St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-16-11

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Nathaniel Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Alice Corkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 DEC 8-1924 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-6 1921

17

I HEREBY CERTIFY, That I attended deceased from 12-2, 1921, to 12-6, 1921, that I last saw him alive on 12-6, 1921, and that death occurred, on the date stated above, at 10 25 p m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute pericarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Cleon B Mason, M. D.

Dec 6. 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	12/8 1921
20 UNDERTAKER	ADDRESS
Mellvaine Cook	507 E North

Spec.—1-10-21—M&T—1500 Bks.

D 59198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 59198

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hebrew Hospital ST., 12 WARD)

2-FULL NAME Baby Boy Berkowitz

(a) RESIDENCE NO. 1865 Druid Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/5/21 8^45 P.M.

7 AGE	Years	Months	Days	If LESS than 1 day, 16 hrs. 30 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Hebrew Hosp.
(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Israel Berkowitz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Rebecca LaBinsky

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant
(Address)

15 Filed DEC 8 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/5/21 8^45 P.M., 1921, to 12/6/21 1^20 A.M.

that I last saw him alive on 12/6/, 1921,

and that death occurred, on the date stated above, at 1^20 P m.

The CAUSE OF DEATH* was as follows:

Premature birth
Atelectasis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Abortus Twin;

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Julius Holzman M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carnegie Lab. (Hopkins)

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

BIRTH should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59199

CERTIFICATE OF DEATH.

105 D 59199

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 Lanvale ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rudolph Lanzel

(Residence in Baltimore: No. 124 Lanvale ave St.; 30 yrs., 0 mos. 0 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Oct (Month) 12 (Day), 1842 (Year)

7-AGE, 79 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Janzen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hauth

(Address) 124 Lanvale ave

15- Filed DEC 8-1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 6 1921, that I saw h.. alive on Dec 6 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) David M. Stuth M. D.

Dec 6., 1921 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mathews

DATE OF BURIAL, Dec 9, 1921

20-UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59200 PLACE OF DEATH

D 59200 REGISTERED NO. C

CITY OF BALTIMORE (No. 2122 Vine ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Florence Christine Selby

(Residence in Baltimore: No. 2122 Vine St St.: yrs. 5 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 12 (Day), 1921 (Year)

7 AGE: yrs. 5 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Selby

11 BIRTHPLACE OF FATHER (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Elsie Williams

13 BIRTHPLACE OF MOTHER (State or country): Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elsie Selby

(Address) 2122 Vine St

15 Filed DEC 8 - 1921 ROBERT J. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 6 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1921. to. Dec 6 1921.
that I saw her alive on Dec 6 1921.
and that death occurred, on the date stated above, at 11.20 m.
The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 4 ds

Contributory (SECONDARY) asthenia

(Duration) yrs. mos. 2 ds.

(Signed) M Byars M. D.

Dec 7, 1921 (Address) 611 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Dec 9 1921

20 UNDERTAKER: W M Rondeau

ADDRESS: 230 N Greene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. — 6-9-16 — H. P. Co. — 1000 Blks.

D 59201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59201

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Galloway

(a) RESIDENCE. NO. 115 S. Dallas St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anna Arundal Co.,
(State or country) Maryland
here in Bal 20 years

PARENTS

10 NAME OF FATHER John Galloway

11 BIRTHPLACE OF FATHER (city or town) Anna Arundal
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lulu Reynolds

13 BIRTHPLACE OF MOTHER (city or town) Anna Arundal
(State or country) Maryland

11 Informant Hospital Records.
(Address) Municipal Hospital.

DEC 8 - 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from November 3, 1921, to December 5, 1921, that I last saw her alive on December 4, 1921, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde O'Neill, M. D.

12/5/1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Dec 8 1921
20 UNDERTAKER	ADDRESS
Wm Robert A Elliott	1726 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

59202 ~~59281~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dispensary Case. H.L.H.

CERTIFICATE OF DEATH.

D 59202

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. ~~JOHNS HOPKINS HOSPITAL~~ 1052 Durham St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jefferson Gordon.

(a) RESIDENCE. No. 1052 Durham St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 11 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) born in Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Hylie Gordon

11 BIRTHPLACE OF FATHER (city or town) Varnville (State or country) So. Carlina

12 MAIDEN NAME OF MOTHER Geneva Berry

13 BIRTHPLACE OF MOTHER (city or town) Belldock (State or country) S.C.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed DEC 8 - 1921 ROBERT I. FEUTEL Registrar

Burial Form Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1921, to Dec 5, 1921, that I last saw him alive on Dec 5, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Thoracic rickets

(duration) yrs. 2-3(?) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elbon C Mason, M. D.

Dec 7. 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 9 1921
20 UNDERTAKER	ADDRESS
Wm Robert A Elliott	1725 Eshland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-0-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59203

CERTIFICATE OF DEATH.

#0 D 59203

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Linden Av ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Simpson

(a) RESIDENCE. NO. 1201 Linden Av ST., WARD. (Resident)
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 81 yrs. 11 mos. 12 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Dec 25-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Brookville Maryland

PARENTS

10 NAME OF FATHER Achilles Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country): A.A. Co. Maryland

12 MAIDEN NAME OF MOTHER Sarah Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A.A. Co. Maryland

14 Informant: Records of Family Bible

(Address) 1201 Linden Ave

15 Filed DEC 8- 1921, 19 ADDEY S. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1904, to March 10, 1921, that I last saw her alive on March 10, 1921, and that death occurred, on the date stated above, at 145 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Mammary Gland and Liver

17 (duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of the Liver

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Large Mammary Mass Liver Large + nodular

(Signed) Flora Wallach M. D.

, 19 (Address) 1112 Eutaw St + 9th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Dec 10 1921.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92D 59204

D 59204

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401. W Pratt St. St.; 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Barnes. Barnes

(a) RESIDENCE. No. 401. W. Pratt St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Antras

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Plano factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania.

PARENTS

10 NAME OF FATHER dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mary Rachunsky
(Address) 910 N Lombard St

15 Filed DEC 8 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-5 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov-30 1921, to Dec. 5 1921.

that I last saw h[illegible] alive on Dec. 5 1921

and that death occurred, on the date stated above, at 11 40 m.

The CAUSE OF DEATH* was as follows: Dic

Lobar Pneumonia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO —

What test confirmed diagnosis? Clinical

(Signed) H G Bridenger M.D.

12-5-21 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 9 1921
20 UNDERTAKER	**ADDRESS**
John Grebliavckas	425 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59205

HEALTH DEPARTMENT—CITY OF BALTIMORE

175-002

D 59205

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH, CITY OF BALTIMORE (No. Mc Henry E Fulton St 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Estrantas

(Residence in Baltimore: No. 1852 Mc Henry St

20 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Autumn, 1 (Month) (Day) (Year)

7-AGE, about 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Lithuania

PARENTS.

10-NAME OF FATHER, John Estrantas

11-BIRTHPLACE OF FATHER, (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER Autumn

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Estrantas

(Address) 1852 Henry St

15-

DEC 8-1921

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Fracture of Neck (Motor Cycle) accd

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

(Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross

DATE OF BURIAL, Dec 9th, 1921

20-UNDERTAKER John Gittemeier

ADDRESS 413 Pac

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59206

CERTIFICATE OF DEATH.

D 59206

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST.) 37 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Biem

(a) RESIDENCE. NO. 400 Belair & Park ave. ST., WARD. Raspeburg. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23		2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lieutenant

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. A.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Biem.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Flom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant John Biem
(Address) 400 N. Belair Rd. Raspeburg

15 Filed , 19 Registrar

DEC 8 1921 Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7. 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 1. , 1921. to Dec. 7 , 1921.

that I last saw h~~im~~ alive on Dec 7 , 1921.

and that death occurred, on the date stated above, at 12.55 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis.

(duration) yrs. mos. 4. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? Raspeburg. Md.

Did an operation precede death? Yes Date of Dec 1. 1921 Dec 6. 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Metcalf , M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Cemetery	Dec. 10 1921
20 UNDERTAKER	ADDRESS
Fredk Loudenslager & Son	Baltimore Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr Zepp 3110 Walbrook ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59207

CERTIFICATE OF DEATH.

v59207

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2957 Clifton ave St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Eckhardt

(a) RESIDENCE. (No. 2957 Clifton ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Ed. Eckhardt

6 DATE OF BIRTH (month, day, and year) Jan 7 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Berlin, Md

PARENTS

10 NAME OF FATHER Herman Pond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Ganz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas Ed Eckhardt (Address) 2957 Clifton ave

15 Filed ....., 19.... Registrar

DEC 8 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6" 1921, to Dec 6" 1921, that I last saw h.. alive on Dec 6" 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? NA Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Herbert E. Zepp, M. D.

Dec 8 1921 (Address) 3210 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 9th 1921
20 UNDERTAKER	ADDRESS
F. B. Wagner	2236 Frederick ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Rynkowska

D 59208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59208

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 702 S Bethel ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2-FULL NAME Sophia Conrad Rynkowska

(Residence in Baltimore: No. 702 S. Bethel St.; 24 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May 15, 1870 (Month) (Day) (Year)

7-AGE, 51 yrs. 6 mos. 22 da. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Joseph Mardas

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sophia Conrad (Daughter)

(Address) 702 S Bethel St.

15-

Filed DEC 8 - 1921 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1921, to Dec 6 1921, that I saw h[illegible] alive on 1921, and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

Empyema

(Duration) yrs. mos. 11 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. da.

(Signed) C. J. Friedman M. D.

12/7, 1921 (Address) 4 S. E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Hedwigs Cem.

DATE OF BURIAL, Dec 10, 1921

20-UNDERTAKER W. F. Sadowski

ADDRESS, 915 S. Ann St

CAUSE OF DEATH to be plainly stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Pleurisy, Effusion
Probably Tuberculous

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59209

CERTIFICATE OF DEATH.

D 59209

REGISTERED NO.....

1-PLACE OF DEATH Forest Park.

CITY OF BALTIMORE: (No. 4303 Main ave ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdaleine R. Ewin

(a) RESIDENCE. No. 4303 Main ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas J Ewin

6 DATE OF BIRTH (month, day, and year) Feby 12 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Weyer's Cave Virginia

PARENTS

10 NAME OF FATHER Col. Jacob Mohler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Frances Jane Ingoby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Thomas J. Ewin
(Address) 4303 Main ave

15 Filed DEC 3 - 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2 . 1921. to Dec 6 . 1921.
that I last saw h alive on Dec 6 . 1921.
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) myocarditis
(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John T Crain M. D.
. 19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 10 192

20 UNDERTAKER Chas. G. Black ADDRESS 742 W Pratt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59210

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Municipal Hospital. ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melchor Zorn.

(a) RESIDENCE. No. 911 Hillen St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	--		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Zorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Hanten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) Municipal Hospital

15 DEC 8-1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1921, to Dec. 6, 1921, that I last saw him alive on Dec. 6, 1921, and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Operative Shock

2 hours. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? Yes Date of Dec. 6--21

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) E. E. Broadaway. M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Dec, 10 1921

20 UNDERTAKER Lilly & Ziler

ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59211

CERTIFICATE OF DEATH.

79 D 59211

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 S. Third St ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schnell.

(a) RESIDENCE. No. 830 S. Third St. ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schnell.

6 DATE OF BIRTH (month, day, and year) Oct. 13 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant + Miners

(c) Name of employer Trans. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Conrad Schnell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Schnabel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mary Schnell. (Address) 1830 E. 3rd St.

15 Filed DEC 8 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/14/21, 19 , to 12/5, 1921, that I last saw h in alive on 12/5/21, 19 , and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insuffiency

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. McGarrell, M. D.

, 19 (Address) 633-S-3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Lawn.

DATE OF BURIAL Dec 9 1921

20 UNDERTAKER Lilly and Zeile

ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59212 CERTIFICATE OF DEATH. 151 D 59212

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Joyner

(a) RESIDENCE. No. 1630 Mullins ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Viola Joyner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant University Hospital Records (Address) Lombard & Greene Sts.

15 Filed ..... 19 ..... Registrar

DEC 8 - 1921

Burial permit issued

18783

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1921, to Dec 5, 1921, that I last saw h[illegible] alive on Dec 5, 1921, and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Abbott Lecce, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL.	
20 UNDERTAKER Commissioner Health.	ADDRESS DEC 8 1921
Per Wm E. WOODALL.	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59213 **CERTIFICATE OF DEATH.** 170 D 59213

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1231 St. Hart alley 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph walter

(Residence in Baltimore: No. 1231 Short alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Widow

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 70+ yrs. ..... mos. ..... ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Unk

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unk

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-
Filed DEC 8 - 1921 191.....
Burial Permit Registered

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic Cystitis Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Snider M. D.
(Coroner.)

12-6, 1921. (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner of Health.
DEC 8 - 1921
WM. R. WOODALL

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87-1

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59214

CERTIFICATE OF DEATH.

79 D 59214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1766 Homestead ST., 9 WARD)

2-FULL NAME Charles J Meyers

(a) RESIDENCE NO. 1766 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widower

5a If married, widowed, or divorced ~~WIFE~~ HUSBAND of: Elizabeth Meyers

6 DATE OF BIRTH (month, day, and year): Dec 24th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooper

(b) General nature of industry, business, or establishment in which employed (or employer): Pennsylvania RR Co

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George Meyers (Address) 1766 Homestead st

15 Filed DEC 8-1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 6 1921

17

I HEREBY CERTIFY, That I attended deceased from July, 1921, to December, 1921, that I last saw h~~im~~ alive on December 6, 1921, and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Lloyd, M. D.

Dec 7, 1921 (Address) 2085 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cemetery — DATE OF BURIAL: Dec 9th 1921

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH D 59215

County

STATE OF MARYLAND
CERTIFICATE OF DEATH

D 59215
Registration Dist. No.

Village or City Baltimore (No. 105 May Ave. St. 27 (Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Ellen Garrity

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	Wh	Widow

6 DATE OF BIRTH: Jan (Month) 8 (Day) 1854 (Year)

7 AGE: 67 yrs. 11 mos. ds. | If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Dougherty

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Dolan

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Garrity

(Address) 105 May Ave, Baltimore

15 Filed DEC 8 - 1921 191 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 7 (Day) 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to Dec. 7, 1921, that I last saw h er alive on Dec 6, 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

(Duration) ? yrs. mos.

Contributory
Secondary

(Duration) yrs. mos.

(Signed) A. L. Dilkinson M.D.

12/8/21 191 Address 13 Bel Air Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State 64 yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Patrick's Cem.	Dec. 9. 1921
20 UNDERTAKER	ADDRESS
Geo. J. Kutts [illegible]	1735 Harford Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HERTZIG ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59216

CERTIFICATE OF DEATH.

105 D 59216

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 301 E. University Parkway ST.) 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda K. Hertzig

(a) RESIDENCE. NO. 301 E. University Parkway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 1 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Austin E. Hertzig

6 DATE OF BIRTH (month, day, and year) Oct. 6th 1893

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wallace H. Kidwell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Barbara Metz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Wallace H. Kidwell
(Address) 301 E. University Parkway

15 Filed DEC 8 - 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1921, to Dec 5, 1921, that I last saw her alive on Dec 5, 1921, and that death occurred, on the date stated above, at 10.30P m.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhea, due to inflammation Large Intestine (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Colitis, ulcers (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Joseph L. Valentine M D.

, 19 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 8 1921

20 UNDERTAKER Jas B Cook

ADDRESS 1003 N. Balto

Spec.—6-9-19—H. P. C.—1000 Bks.

D 59217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59217

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO 672 Columbia ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Kyne

(a) RESIDENCE. NO. 672 Columbia ave ST.. ..... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Kyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Feney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Bridget Kyne
(Address) 672 Columbia ave

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

Robert F Heffron,

C 8-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1921

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1921, to Dec 6, 1921.
that I last saw h[illegible]ive on Dec 6 1921.
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? The Symptoms

(Signed) Edward Gross, M. D.

19 (Address) Corner Fulton & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Augustine Elkridge Md	Dec 9 1921
20 UNDERTAKER James Dignan & Son	ADDRESS 1000 S. Sara

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59218

CERTIFICATE OF DEATH.

79 D 59218

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 1812 Guilford Ave. W WARD)

2-FULL NAME Mary Norton

(a) RESIDENCE. No. 1812 Guilford Ave 12 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? 74 yrs. ~ mos. ~ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of the late Patrick Norton

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Bernard Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Honora Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Dr. E. C. Dohme 3014 St Paul St.

15 Filed 8-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from August, 1921 to Dec. 6th, 1921 that I last saw her alive on Dec 5th, 1921 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) 6 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis (duration) 15 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

12/7/1921 (Signed) Gustavus C. Dohme, M. D. (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Grave	12/9. 1921
20 UNDERTAKER J. J. Bakey & Sons	ADDRESS 13 [illegible] St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59219

92

D 59219

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 622 N. Bethel (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry M. Lowe

(a) RESIDENCE. No. 622 N. Bethel St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced, HUSBAND of (or, ~~WIFE of~~) Selina Lowe

6 DATE OF BIRTH (month, day, and year) July, 4, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer for 40 yrs

(b) General nature of industry, business, or establishment in which employed (or employer) Mutual Chemical Co

(c) Name of employer Mutual Chemical Co. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) mrs Selena Lowe (wife)

15 Filed 19 Robert P. Harrison, Registrar

C 8 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6 1921

17 I HEREBY CERTIFY, That I attended deceased from July. 6, 1921, to dec. 6, 1921, that I last saw him alive on dec 5 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia due to chemical irritation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemmorhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) R J Mooney, M. D.

, 19 (Address) 1429 Monument E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn	Dec 9 1921

20 UNDERTAKER	ADDRESS
P C Gross	1405 McElderry

CAUSE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59220

CERTIFICATE OF DEATH.

10-04

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 22 Wormer st ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas L Farris

(Residence in Baltimore: No. 22 Wormer st

St. 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Col'd	Single

6-DATE OF BIRTH, 2 (Month) 18 (Day) 1856 (Year)

7-AGE,	If LESS than 1 day,
35 yrs. 9 mos. 13 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joshua Jarris

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Susan Rodgers

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Hicks - Mistress

(Address) Last known

15-

Filed ....., 1921 Robert P. Harrison

Registrar.

C 8-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 6 (Day) 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1921, to Dec 5 1921, that I saw h im alive on Dec 5 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

..... (Duration) yrs. mos. 3 ds.

(Signed) Thos B Hall M. D.

12-7-, 191... (Address) Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Cem	Dec 9..., 1921
20-UNDERTAKER	ADDRESS 114 N
Brown & Sheeland & Schroeder	

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spmc—6-3-19—H. P. Co.—1000 Blks.

(Alexalzer) V 92

D 59221

HEALTH DEPARTMENT—CITY OF BALTIMORE

Exact Brooklyn

D 59221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 27 Third Ave St. 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Alexsalzer

(a) RESIDENCE (Usual place of abode) NO. 27 Third Ave ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1/21

7 AGE: Years: six; Months: 7; Days:; If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): E. Brooklyn Md

PARENTS

10 NAME OF FATHER: Frank Alexsalzer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia Poland

12 MAIDEN NAME OF MOTHER: Eva Janyszki

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia Poland

14 Informant (Address): Frank Alexsalzer 27 Third Ave E.B.

15 Filed 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1921, to Dec 8, 1921, that I last saw him alive on Dec. 2, 1921, and that death occurred, on the date stated above, at 11.25a m.

The CAUSE OF DEATH* was as follows:

Chronic Pleurasy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia unknown as I did not attend him at that time

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. J. Horlay M. D.

, 19 (Address) Cedar St. E.B.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 9 1921
20 UNDERTAKER: Jos. Trialkowski	ADDRESS: Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FC P-1091

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, telanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculer
Had a Pleumpneumonia

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59222

D 59222

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Olkowski

(a) RESIDENCE. No. 226 S. Madeira st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Olkowski

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Crane operator

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Michael Olkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Hospital Records (Address) M. T. H.

15 Filed 12-6-1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1921, to Dec. 5, 1921, that I last saw him alive on Dec. 5, 1921, and that death occurred, on the date stated above, at 9.57 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum

(Signed) Francis L. Badgley M. D.

12-6-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 9 1921
20 UNDERTAKER	ADDRESS
William Jaekowski	468 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59223

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Hament

(a) RESIDENCE. No. 2852 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 12, 7[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	71	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Robert Ha[illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Ben Hament
(Address) 2853 W North Ave

15 Filed Dec 8 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

C 8-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 19 21 to Dec 8 19 21,
that I last saw h[illegible] alive on Dec 8 19 21,
and that death occurred, on the date stated above, at 6 [illegible] m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bulls Head Cemetery	Dec 8 1921
20 UNDERTAKER Mat Lennon	ADDRESS 1148 Bulls H

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59224

CERTIFICATE OF DEATH.

64 ✓

D 59224

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6015 Falls Road. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME Instead of street and number.)

2-FULL NAME Margaret L. Keaney

(a) RESIDENCE. No. 6015 Falls Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Timothy Keaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jennie Rhoddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mary Keaney
(Address) 6015 Falls Rd

15 Filed DEC 9 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/6/21, 19 , to 12/7/21, 19 , that I last saw h e alive on 12/6/21, 19 , and that death occurred, on the date stated above, at 1 AM. m.

The CAUSE OF DEATH* was as follows:

Hemoplegia Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 6015 Falls Rd.

Did an operation precede death? Date of no.

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) [illegible] M. D.

, 19 (Address) Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Woods	Dec 9 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Fivas

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59225

CERTIFICATE OF DEATH.

138 D 59225

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sayth Balto Hospital St.; 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Fivs

(a) RESIDENCE. No. 901 S Paca St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. 13 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white Russian

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyman Fivs

6 DATE OF BIRTH (month, day, and year): Oct. 16, 1889

7 AGE: Years 32; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Krkenonoe Russia

PARENTS

10 NAME OF FATHER: David Aborty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Krkhonoe Rugsia

12 MAIDEN NAME OF MOTHER: Rebeca Aborty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Krkenonoe Russia

14 Informant: Louis (Address) 1611 Eutaw St

15 [illegible] DEC 9 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/6, 1921, to 12/8, 1921, that I last saw her alive on Dec 8, 1921, and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis & Prolonged Labor (contracted pelvis)

(duration) ? yrs. mos. 3 days

CONTRIBUTORY (Secondary): Acute Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Sokorny, M. D.

, 19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 12/9 1921

20 UNDERTAKER: Jack Lewis — ADDRESS: 1611 Eutaw

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59226

CERTIFICATE OF DEATH.

1704 D 59226

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1630 (St.) Light (St.) 23 (Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie M. Watts

(a) RESIDENCE. No. 1630 Light St. (St.)..... WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua S. Watts

6 DATE OF BIRTH (month, day, and year) Aug 26 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Glenburnie Md

PARENTS

10 NAME OF FATHER Hm Newshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Glenburnie Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Joshua S. Watts (Address) 1630 Light St

15 Filed . 19 DEC 9-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-12 1921, to 12-7 1921, that I last saw her alive on 12-7 1921, and that death occurred, on the date stated above, at 3.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James Brown, M. D.

. 19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tubbe Cemetery Co	Dec 9 1921
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 59227

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 46 Mason St. Masonville ST.: 25 WARD)

2-FULL NAME Frank Joseph Schelegki

(a) RESIDENCE. NO. 46 Mason St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, ~~widowed or divorced~~ BUSBAND of ~~or WIFE of~~ Annie G. Schelegki

6 DATE OF BIRTH (month, day, and year) June 4 1883

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	38	6	2	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) " 015

(c) Name of employer Various Philadelphia

9 BIRTHPLACE (city or town) Philadelphia Pa.
(State or country)

PARENTS

10 NAME OF FATHER Stephen Schelegki

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Josphine Lambert

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Annie G. Schelegki
(Address) 46 Mason St

15 Filed DEC 9 - 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1921, to Dec. 7, 1921, that I last saw him alive on Dec. 6, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacilli in Sputum

(Signed) Geo. B. Davis, M. D.

12/7 1921 (Address) Curtis Bay, Md. 211 Church St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery A A Co Md	Dec 10 1921
20 UNDERTAKER John H. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Fox St. ST. 17 WARD) 170

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Elizabeth Lewis

(Residence in Baltimore: No. 2804 Fox st St.; 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1869 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Home. 060
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Not Employed

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jacob Billings

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Caroline Harris

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. S. Lewis

(Address) 2804 Fox st.

15- BOARD OF HEALTH

Filed DEC 9 - 1921 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30th 1921, to Dec 7th 1921, that I saw h[er] alive on Dec 5th 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry T. Brown M. D.

Dec 9th, 1921. (Address) 1501 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Dec 9th, 1921

20-UNDERTAKER Samuel T. Hemsley

ADDRESS 578 W Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59229

D 59229

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 East ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Cummings

(a) RESIDENCE. No. 109 East ST., 5 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Cummings

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westmoreland

12 MAIDEN NAME OF MOTHER Unknown 12-7, 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westmoreland

14 Informant Hattie Bates
(Address) 109 East St.

15 Filed . 19 ROBERT S. LEATHERS Registrar

DEC 9-1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6. 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1921, to Dec. 5, 1921, that I last saw h[illegible] alive on Dec 5, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

(Address) 1201½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashburn Cemetery	Dec 9 1921
20 UNDERTAKER Samuel Townsley	ADDRESS 1[illegible] W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59230

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1606 N Monroe ST.: 15 WARD)

2-FULL NAME Susan E Carmady

(a) RESIDENCE. No. 1606 N Monroe ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

REGISTERED NO. D 59230

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William E Carmady

6 DATE OF BIRTH (month, day, and year): Oct 25 1863

7 AGE — Years: 58 Months: 1 Days: 13

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Andrew Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Julia Biddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): William E Carmady 1606 N Monroe St

15 Filed DEC 9 - 1921 [illegible] Registrar

[illegible] Clerk

Copy page 2303 N Calvert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 11 1921 to Dec 7 1921, that I last saw h[illegible] alive on Dec 7 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis
Acute Dilatation of the Heart (duration) .... yrs. 8 mos. .... ds.

CONTRIBUTORY (Secondary) Chronic Valvula Heart disease (duration) 3 yrs. 2 mos. .... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) W H Copage, M. D.

, 19 (Address) 2303 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	Dec 11 1921
20 UNDERTAKER	**ADDRESS**
William Beck	502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates

Spec.—1-10-21—M&T—1500 Bks.

D 59231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 59231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1322 W. North Ave ST. 15 WARD)

2-FULL NAME Frederick A. Hartshorne

(a) RESIDENCE NO. 1322 W. North Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora L. Hartshorne

6 DATE OF BIRTH (month, day, and year) Feb. 9, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron & Steel Bus.

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer Retired.

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER James Hartshorne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Penna

12 MAIDEN NAME OF MOTHER Harriet Kimball 12/8 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Chas E Hartshorne

(Address) 1322 W. North Ave

15 DEC 9 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1921, to Dec 7th, 1921, that I last saw him alive on Dec 7th, 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Herbert E. Gebb M. D.

(Address) 3210 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 9 1921
20 UNDERTAKER Wm Fickus & Sons	ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H, P. Co.—1000 Bks.

Guy De Buissereti

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59232 (1534)

X 74 D 59232

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (St.:) (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guy De Buissereti

(a) RESIDENCE. No. 1519 St Paul St. Washington D.C. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-8-02

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mid Shipman

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.N.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belgium

PARENTS

10 NAME OF FATHER Evrad de Buissereti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brussels

12 MAIDEN NAME OF MOTHER Caroline Story

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 JOHNS HOPKINS HOSPITAL. Informant

(Address) Records

15 Filed DEC 9 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8- 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct-24 , 1921 , to Dec 8- , 1921 , that I last saw him alive on Dec 8- , 1921 , and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Cerebellum

(duration) 7 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Nov. 6 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Holman , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Naval Cemetery Encpolis	Dec 10 1921
20 UNDERTAKER B L Hopkins	ADDRESS Encpolis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59233

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N. Durham. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Miller.

(a) RESIDENCE No. 922 N. Durham. ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas F. Miller.

6 DATE OF BIRTH (month, day, and year) Dec 9th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework. 937

(b) General nature of industry, business, or establishment in which employed (or employer): at Home.

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas F. Miller.
(Address) 922 N. Durham St

15 Filed DEC 9 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1921

17 I HEREBY CERTIFY, That I Attended deceased from Dec 1st, 19 21, to Dec 7th, 19 21, that I last saw h alive on Dec 7th, 19 21, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Broncho Pneumonia
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Tyner, M. D.

Dec 9th, 19 (Address) 1801 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 10th 1921

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 4033 Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59234

CERTIFICATE OF DEATH.

146 ✓ D 59234

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 Fulton Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Coley Parrish.

(a) RESIDENCE. No. 650 Fulton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Lady.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Gideon Parrish.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Agnes Baker

(Address) 650 Fulton Ave.

15 FILED DEC 9 - 1921 BOARD OF HEALTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 8th 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1921, to Dec 8th, 1921, that I last saw h[illegible] alive on Dec 8th, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Suppuration Extremities

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) [illegible] M. D.

(Address) 401 E 45th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery Govans	Dec 12 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Leifield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59235

D 59235

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 N. Washington St. WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Leifield

(a) RESIDENCE NO. 827 N. Washington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — da. How long in U. S., if of foreign birth? — yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John B Leifield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Diedrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. May Leifield

(Address) 827 N Washington St B

15 Filed DEC 9 - 1921 (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 9, 1921, that I last saw h/r alive on Dec 8, 1921, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Heart Disease

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senile Insufficiency

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John A. Fick M. D.

12/9, 1921 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 12 1921
20 UNDERTAKER	ADDRESS
Henry Boeck & Son	1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 59236 (15 95)

CERTIFICATE OF DEATH.

X 51 D 59236

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Colman Cutright

(a) RESIDENCE. NO. Queens Creek Va ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-10-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Melvin Cutright

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Ettie Hollins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Grant

15 Filed DEC 9-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-19 1921 to 12-9 1921 that I last saw him alive on 12-9 1921 and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Goitre, exophthalmic,

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Midvale W. Va	Dec 9 1921
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 N Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59237 CERTIFICATE OF DEATH. 79 D 59237

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Wells

(a) RESIDENCE. No. 1031 Vincent St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Emmet Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed DEC - 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from November 30, 1921, to December 7, 1921, that I last saw him alive on December 6, 1921, and that death occurred, on the date stated above, at 1:00 A.M. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

12/7/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL DEC - 1921

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59238

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1920 D 59238

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 2708 Guilford Ave. St. 17 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Christian Reamer

(Residence in Baltimore: No. 2708 Guilford Ave St.: 12 yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: January 8, 1849 (Month) (Day) (Year)

7 AGE: 72 yrs. 11 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer): Hotel Clerk

9 BIRTHPLACE (State or country): Penna.

PARENTS

10 NAME OF FATHER: Wm. C. Reamer

11 BIRTHPLACE OF FATHER (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Abigail Mann

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary R. Cornell

(Address) 2708 Guilford Ave

15. Robert F. Harrison,

Dec 9, 1921 Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 8th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7th, 1921, to Dec 8th 1921 that I saw him alive on , 191 . and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension (Duration) Unknown yrs. mos. ds

Contributory (SECONDARY) Uremia (Duration) yrs. mos. 3 ds.

Signed Frederick L. Owen M. D.

Dec 9, 1921 (Address) 2527 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Middleburg Md DATE OF BURIAL: Dec 10 1921

20 UNDERTAKER: John O. Mitchell ADDRESS: 201 N. Fayette

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59239

CERTIFICATE OF DEATH

80

1-PLACE OF DEATH Church Home + Hosp.

REGISTERED NO.....

CITY OF BALTIMORE: (No. N. Broadway ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Fredrick J. Billings

(a) RESIDENCE. No. 1526 Linden ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	American	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara B. Billings

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Promoter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Darius Billings

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Daugo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Mrs. C. Billings

(Address) 25 Park Pl. N.Y.

15 Filed Robert P. Garrison Registrar

9-1921 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1921, to Dec 8, 1921, that I last saw him alive on Dec 8, 1921, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows: Angina pectoris

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Nephritis Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Noble, M. D.

, 19 (Address) Church Home Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cincinnati Ohio	Dec 10 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Harms)

D 59240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59240

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2037 E Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan P. Harms

(a) RESIDENCE. NO. 2037 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Harms

6 DATE OF BIRTH (month, day, and year) July 28 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Adam E. Jenkins

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Arnold

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Charles H. Harms
(Address) 2037 E. Biddle St.

15 Filed Dec 9-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Dec 7, 1921, that I last saw her alive on Dec 7, 1921, and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

Laryngeal and pulmonary tuberculosis

(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm T Watson, M. D.

Dec 8, 1921 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 10 1921
20 UNDERTAKER	ADDRESS
Elmer N. Conklin	724 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITIONS should be stated EXACTLY. PHYSICIANS should TION is very important. See instructions on back of certificates.

D 59241 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59241

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1739 Hanover St. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Amelia Yeakel.

(Residence in Baltimore: No. 1739 Hanover St.

40 ---------
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, September 30th. 1846, 1
(Month) (Day) (Year)

7-AGE, 75 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 100
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Germany.

PARENTS.

10-NAME OF FATHER, John Horst.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Wilson. (daughter)

(Address) 1739 Hanover St.

15-

Filed DEC 9-1921, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 7th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Dec. 8th., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western DATE OF BURIAL, Dec 10, 21

20-UNDERTAKER Little Cook ADDRESS 702 E Monument

D.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59242

64 D 59242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1004 Edmondson Avenue

CITY OF BALTIMORE: (No. 1004 Edmondson Avenue ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Genevieve Althoff

(a) RESIDENCE NO. 1004 Edmondson Avenue ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis S. Althoff

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	-	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel W. Morrow

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Elizabeth Foy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Irving D. Hinton
(Address) 523 N. Fulton Ave., Balto., Md.

15 Filed 9-1921, 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1921, to Dec. 9, 1921,

that I last saw her alive on December 9, 1921,

and that death occurred, on the date stated above, at 12:25 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemiplagia, left.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) [signature] M. D.

12/9 1921 (Address) 1002 Edmondson Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery — DATE OF BURIAL Dec. 11 1921

20 UNDERTAKER George E. Schnaf. — ADDRESS 2101 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

See Affidavit ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59243

CERTIFICATE OF DEATH.

X 7

1-PLACE OF DEATH

CITY OF BALTIMORE: No Mercy Hospital ST.: WARD: 4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph Bruder & Ignatz Bruder

(a) RESIDENCE. NO. Gibbon, Minn. ST., WARD

(Usual place of abode) (If nonresident give city or town and State) Gibbon, Minn.

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10 NAME OF FATHER Bernard Bruder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Minn.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mercy Hospital Record

(Address)

Filed C 9 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

Via American Railway Express.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 21, 19..., to DEC. 9 21, 19..., that I last saw him alive on DEC. 9, 1921, and that death occurred, on the date stated above, at 9:30A. m.

The CAUSE OF DEATH* was as follows:

(1) 2nd & 3rd Degree Burns Body & Lower Extremities

Contributed to by Toxemia (over)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Scarlatina

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? (1) Home 808 N. Calvert (2) Hospital

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Sugar & Brompton's

(Signed) John J. Erwin, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gibbon, Minnesota	12/9 1921
20 UNDERTAKER Henry W. Means & Son	ADDRESS 805 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Caught on fire while cleaning and pressing his clothes. September 30/21 at 808 N. Calvert St.

MERCY HOSPITAL
CONDUCTED BY THE SISTERS OF MERCY
CALVERT & SARATOGA STS.
BALTIMORE, MD.

December 29,1921.

TO WHOM IT MAY CONCERN:-

This is to certify that the name of the Father of Joseph Binder (Deceased) was incorrectly inserted in the Death Certificate as Bernard Binder, whereas it should be Ignatz Binder.

The Records at Mercy Hospital have been corrected accordingly.

Very truly yours,

John J. Erwin, M.D.

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:-

I HEREBY CERTIFY that on this 29th day of December in the year of one thousand nine hundred and twenty one, before me the subscriber a Notary Public of the State of Maryland in and for the City of Baltimore aforesaid, personally appeared Jno.J.Erwin, M.D., and made oath in due form of law that the above statement is true as therein states to the best of his knowledge and belief.

WITNESS my hand an Notorial Seal

Sister M. Seena
.....
Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59244

CERTIFICATE OF DEATH.

107

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... St. Joo. Hospital 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kelly

(a) RESIDENCE. No. 1035 Forest ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	11	6	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Fireman at

(b) General nature of industry, business, or establishment in which employed (or employer) Base hosp. at

(c) Name of employer Camp Meade

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Miss Maria Kelly 1035 Forest St

15 Filed ..... 19..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1921

17 I HEREBY CERTIFY, That I attended deceased from 10-14 1921, to Dec. 7 1921, that I last saw him alive on Dec. 6 1921, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Ruptured gastric ulcer.

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Subphrenic abscess

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-28-21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J O'Conte, Jr, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec. 10 1921
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Eighth St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4863

(Schepers)

D 59245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59245

CERTIFICATE OF DEATH.

167

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 211 Josh Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Emma Schepers

(Residence in Baltimore: No. 508 S. Clements St.; yrs. 65 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 73 yrs. 11 mos. 18 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. housework
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Holland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Holland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Holland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Gotee

(Address) 508 S. Clement St.

15- Filed DEC 9 1921, 191.....

Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Flame Shock
Accidental Fire.
(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... da.

(Signed) H. Kelly M. D.
12-9, 1921 (Coroner)
(Address) 4 E. Lee St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. G.A.C. — DATE OF BURIAL, Dec 12 1921

20-UNDERTAKER Margaret D. Flynn — ADDRESS 1411 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Gasoline stove exploded

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

(McCloskey)

D 59246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59246

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH — CITY OF BALTIMORE (No. 9 N Hilton St. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robt McCloskey

(Residence in Baltimore: No. 2127 Huntington Ave. St.; yrs., 70 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, August (Month) 4 (Day), 1844 (Year)

7-AGE, 77 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Hdw

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: John McCloskey

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: not known

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McCloskey

(Address) 2127 Huntington Ave.

15-

Dec 13 1921

Robert F. Harrison, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Left

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. E. Kidd M. D.
(Coroner.)

Dec 9 1921 (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
The Holy Cross Cem	Dec 12, 1921
20-UNDERTAKER W. W. Shriver	ADDRESS 1018 Edmondson Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 59247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59247

CERTIFICATE OF DEATH.

150

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Augusta St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Russell Alban.

(Residence in Baltimore: No. 1710 Augusta St.; yrs., mos. 1½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	S

6-DATE OF BIRTH, Dec 7, 1926.
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 40 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....000....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Glennie Alban

11-BIRTHPLACE OF FATHER (State or Country), Balto Colrd.

12-MAIDEN NAME OF MOTHER Stella May Hale

13-BIRTHPLACE OF MOTHER (State or Country), Balto Colrd

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Glennie Alban

(Address) 1710 Augusta St

15-

Robert P. Harrison,

Filed ....., 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1926.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1926, to Dec 9, 1926, that I saw h[illegible] alive on Dec 8, 1926, and that death occurred, on the date stated above, at 24 hr. m.

The CAUSE OF DEATH* was as follows:

Morbus Cordeus

(Duration) ....yrs....mos. 1½ ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Howard Glenn M. D.

Dec 9, 1926. (Address) 1736 Bway Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Forest cemetery	Dec 11..., 1926
20-UNDERTAKER	ADDRESS
E & Roy Stiffler	1215 Mall Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59248

D 59248

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Park Heights Ave. Near Glen Ave. ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John J. Kerns

(a) RESIDENCE. NO. Park Heights Ave. Near Glen Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Johannes, nee

6 DATE OF BIRTH (month, day, and year) Dec. 12, 186[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	25	

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work: Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Armstrong Cator Co, Baltimore.

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Hugh Kerns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Isabel McGehean

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Addie Kerns

(Address) Park Heights Ave. nr Glen Ave

15 Filed Robert P. Harrison Registrar

9-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1921, to Dec 7, 1921, that I last saw h[illegible] alive on Dec 7, 1921, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs about mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Louis Staylor, M. D.

, 19 (Address) Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	12/10 19[illegible]
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: 24 WARD) 175.00

2-FULL NAME John Franklin

(Residence in Baltimore: No. 111 E Hamburg St.; 6 yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 8 (Day), 1 (Year)

7-AGE, 47 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country): Pa

PARENTS.

10-NAME OF FATHER, Jno. Faulkner

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), X

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Faulkner

(Address) 111 E Hamburg

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

C 9-1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Double fract of skull
Contusion - and Hemm
Run under auto truck & wagon

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

June 7, 1914. (Address) 1659 Bel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Chester Pa	June 10, 1914
20-UNDERTAKER	ADDRESS
F.A. Kramer & Son	703 Hanover

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form —6-9-19—H. P. Co.—1000 Bks.

D 59250 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59250

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hark

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28th WARD. (Cumberland Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 8 mos. ds. How long in U. S., if of foreign birth? 33 yrs ~ mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April - 1868

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or min.
	33 yrs	8 mos	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Peter Hark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Md.

12 MAIDEN NAME OF MOTHER Eliz. E. Nris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md.

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Retreat

15 Filed 19 Robert P. Harrison, Registrar
-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5th, 1916, to Dec 9th, 1921, that I last saw h[illegible] alive on Dec 9th, 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hypoplexy - (Sudden).
Abt 10 minutes -
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Feebleminded from Birth
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cumberland Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Dec 9, 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland Md	Dec 9/E 21
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

D 59251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59251

CERTIFICATE OF DEATH.

91

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2126 Oak Street) (St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loretta Kratz

(Residence in Baltimore: No. 2126 Oak Street St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Nov (Month) 25 (Day) 1911 (Year)

7-AGE: 10 yrs. mos. 13 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Wm D. Kratz
11-BIRTHPLACE OF FATHER (State or Country): W. Va
12-MAIDEN NAME OF MOTHER: Mary K Moore
13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm D. Kratz
(Address) 2126 Oak Street

15-
Filed ....., 191.....
Robert P. Harrison, Registrar.
Burial Permit Clerk.

DEC 9 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. (Month) 9 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D.
(Coroner.)
Dec 9, 1921. (Address) 3632 Reisterstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Forest Lawn
DATE OF BURIAL: 12/10, 1921

20-UNDERTAKER: Sullivan Co
ADDRESS: 5026 Park Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. CITY OF BALTIMORE: (No.) Mercy Hospital (St.:) 17 (Ward) — REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master Charles Bagnal

(a) RESIDENCE: (No.) 2100 Greenmount Ave (St.) (Ward)
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 13, 1917

7 AGE — Years: 4 — Months: 10 — Days: 26 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of Industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS
10 NAME OF FATHER: Henry Bagnal
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore md.
12 MAIDEN NAME OF MOTHER: Bessie Bazzell
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Henry C Bagnal
(Address): 2100 Greenmount Ave

15 Filed DEC 9-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1921, to Dec 9, 1921
that I last saw him alive on Dec 9, 1921
and that death occurred, on the date stated above, at 3:55 P.M.
The CAUSE OF DEATH was as follows:*
Multiple abscess of Extremities & Scalp.
(duration) yrs. 1 mos. 7 ds.
CONTRIBUTORY (Secondary) Femoral Septicemia and Pyaemia (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? yes Date of Nov. 26, 21
Was there an autopsy? Incision & draining Date of Dec. 3, 21
What test confirmed diagnosis? abscess
(Signed) John J Kerwin M. D.
(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery — DATE OF BURIAL: 12/10 1921
20 UNDERTAKER: William Corl & — ADDRESS: 50 & Main

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59253

CERTIFICATE OF DEATH.

175-001 D 59253

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Carlton Johnstone

(Residence in Baltimore: No. 2 Anthony Ave.

St.; yrs. 28 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 15 (Day), 1886 (Year)

7-AGE, 31 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Elect.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Jas Johnstone

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jane Jack.

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Johnstone.

(Address) 2 Anthony Ave

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

C 101921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull,
accidentally thrown from Automobile when auto struck Curb,
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D.
(Coroner.)
Dec 10, 1921 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Dec. 10, 1921
20-UNDERTAKER H. Sander Sons	ADDRESS 1710 Eutaw St.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(See Letter Over)

D 59254 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D 59254

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1312-E. Lafayette Ave ST., 5 WARD)

2-FULL NAME Emma A. Schafer

(a) RESIDENCE NO. 1312-E. Lafayette ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or WIFE of Charles Schafer

6 DATE OF BIRTH (month, day, and year) March 3rd 1868

7 AGE Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
53	9	5	~~If LESS than 1 day ...hrs. or ...min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John P. Pomoser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER D. Piel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Charles A. Schafer
(Address) 1312-E. Lafayette ave

15 Filed ..... 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

C 1 01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to Dec 8, 1921, that I last saw h... alive on Dec 7, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of Heart

(duration) yrs. 7 mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. W. Sanderson M. D.

. 19 (Address) 714 N. Carol... ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Dec 12 1921
20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Hanford ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DR. JOHN W. SANDERSON

1714 N. CAROLINE STREET

C. & P. TELEPHONE

BALTIMORE, MD. May 3 1942

Dr C. Hampendorf
Dear Doctor

1312 E. Lafayette av. died on Dec 8. 1941.
Mrs Emma A. Schober.

yours respectfully
John W. Sanderson MD
1714 N Caroline St

(Stuckey)

D 59255 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2245 W. Lexington St. 16 WARD) REGISTERED No. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carolyn R. Stuckey

(Residence in Baltimore: No. 615 N. Eutaw St.)

St.; yrs., 17 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 23, 1898
(Month) (Day) (Year)

7-AGE, 43 yrs. 5 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Penna

PARENTS.

10-NAME OF FATHER, Chas. Scheit

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Nuhsmann

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Stuckey

(Address) 615 N. Eutaw St.

15- Robert P. Harrison, ..., 191.....
Registrar.

FEB 6 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, DEC 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Fracture of Skull,
(Cerebral Concussion) Injuries Received
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) G. C. Blades M. D.
(Coroner.)

Dec 10, 1917 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn — DATE OF BURIAL, Dec 12, 1917

20-UNDERTAKER Apple & Little — ADDRESS 1711 Edmondson

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

(Harry B. Collins)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59256

CERTIFICATE OF DEATH.

92 D 59256

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 70 WARD) A

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry B. Collins,

(Residence in Baltimore: No. 121 S- Paca St St.; 6 yrs., 3 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH. Oct (Month) 31 (Day), 1915 (Year)

7-AGE, 6 yrs. 3 mos. 8 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): Boy

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Morris J Collins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Edith M Corr

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marian Collins

(Address) 1412 McCulloh St

15-

Filed Dec 8 1921 Robert F. Harrison, Registrar.

EC 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1921, to Dec 8 1921, that I saw h~~im~~ alive on Dec 8 1921, and that death occurred, on the date stated above, at 10:17 m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Myocarditis & Chol

(Duration) ....yrs....mos....ds.

(Signed) Henry C Wortis M. D.

Dec 8, 1921 (Address) Franklin & Hop

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 9 mos. ds. In the State 6 yrs. mos. ds.

Where was disease contracted if not at place of death? Home 121 S Paca st

Former or usual residence 121 S Paca st

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Peters	Dec 10, 1921

20-UNDERTAKER	ADDRESS
John J Reilly	1300 N Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks .....

Lobar Pneumonia.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

D 59257. HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 59257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 24 Albemarle ST. 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kaspar Rameika

(Residence in Baltimore: No. 24 albemarle St

St.; yrs. 31 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, John Rameika

11-BIRTHPLACE OF FATHER (State or Country). Lithuania

12-MAIDEN NAME OF MOTHER Ellen Zagaite

13-BIRTHPLACE OF MOTHER (State or Country). Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gatkowski

(Address) 425 S Paca St

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

10 1921

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Ryan M.D.
(Coroner.)

Dec 10, 1921 (Address) 800 W Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Dec 10, 1921

20-UNDERTAKER	ADDRESS
John Szeliauckas	425 S Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59258

CERTIFICATE OF DEATH.

92-078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2643 E. Monument ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Weller

(a) RESIDENCE. No. 2643 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 10 mos. 30 ds. How long in U. S., if of foreign birth? 8 yrs. 10 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 9-

7 AGE — Years: 8 — Months: 10 — Days: 30 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Fred J. Weller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lelia M. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Fred Weller 2643 E. Monument

15 Filed DEC 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8th 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1921, to Dec 8, 1921, that I last saw her alive on Dec 8, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos. 2 ds.

Lobar Pneumonia

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Meyer Jr. M. D.

12/9/1921 (Address) 1638 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem. — DATE OF BURIAL: Dec 11 21

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Aliceanna

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59259

D 59259

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 157 Cooksie Ave ST.; 20 WARD)

2-FULL NAME Mary C. Crews

(a) RESIDENCE. No. 157 Cooksie Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Crews

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co

PARENTS

10 NAME OF FATHER John J. Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary A Reidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant (Address) Mrs Mary A Bauer Fredk Rd & Beechfield

15 Filed ....., 19 Robert P. Harrison, Registrar

C 10192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1920, to Dec 9, 1921, that I last saw her alive on Dec 9, 1921, and that death occurred, on the date stated above, at 6.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yr. 2 mos. ds.

CONTRIBUTORY (Secondary) Nervous Hysteria and Insanity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones, M. D.

Dec 9, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 12, 1921
20 UNDERTAKER C. W. Dill	ADDRESS 310 Fredk Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59260

CERTIFICATE OF DEATH.

D 59260

REGISTERED NO. 19

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 803 N. Madeira St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Backstein

(a) RESIDENCE. No. 803 N. Madeira St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced (Husband of (or) Wife of): Wm F. Backstein

6 DATE OF BIRTH (month, day, and year): Nov 17-59

7 AGE — Years: 62 — Months: — — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Borrmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Wm F. Backstein 803 N. Madeira

15 Filed DEC 10 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1921 to Dec 8 1921

that I last saw h alive on Dec 7 1921

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

12-8. 1924 (Address) 800 N. Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Dec 10 1921
20 UNDERTAKER: Philip Herrig	ADDRESS 2046 Aisquith

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59261 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59261

91-081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USPHS Hospital #56, Ft. McHenry REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md.. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stockley, Joshua

(a) RESIDENCE NO. USPHS Hospital #56, Baltimore, Md.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) -- (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant E.T. Rosenbrock (Address) Registrat

15 Robert P. Harrison, Registrar

C 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9/21 19

17 I HEREBY CERTIFY, That I attended deceased from 11/26/21, 19, to 12/9/21, 19, that I last saw him alive on 12/9/21, 19, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia-Broncho

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis general & senile

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry R. Payne, M. D.

12/10, 1921 (Address) Senior Surgeon (R) USPHS Hosp #56, Balto. Md..

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Dec 9, 1921

20 UNDERTAKER S. Lennon & Bro

ADDRESS 114 E. Balto. St.

B. WHITE PAPER, FOR PHYSICIANS. GREEN PAPER, FOR UNDERTAKERS. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59262

HEALTH DEPARTMENT—CITY OF BALTIMORE.

79 D 59262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 W Balto ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. F. Krause

(a) RESIDENCE NO. 2213 W Balto St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catharine E. Krause

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 57 — Months: 7 — Days: — — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm F. Krause

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bertha Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Howard E. Krause 2213 W. Balto St.

15 Filed ..... 19 ..... Registrar

C 101921 Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1921, to Dec 8, 1921, that I last saw h[illegible] alive on Dec 7, 1921, and that death occurred, on the date stated above, at 10.50 p m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Lesion

Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Pulm. congestion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam & Hist

(Signed) Chas F Blake, M. D.

Dec 10 1924 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Dec 12 1921

20 UNDERTAKER: John Ottenberg — ADDRESS: 1201 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 59263

15 D 59263

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No.) ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophnie Mc Gloden

(a) RESIDENCE. No. 935 N. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) unknown 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md

PARENTS

10 NAME OF FATHER Edward Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilhelmina Pinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed DEC 10 1921 19 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7 1921

17

I HEREBY CERTIFY, That I attended deceased from 9-28, 1921, to 12-7, 1921, that I last saw her alive on 12-7, 1921, and that death occurred, on the date stated above, at 10 15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Endocarditis chr.

Pericarditis chr.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 7 21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Goldman, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 10. 1921

UNDERTAKER Mrs Robert + Elliott

ADDRESS 1726 Fehland Ave

should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE it may be properly classified. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59264

CERTIFICATE OF DEATH.

29

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Webb

(a) RESIDENCE. NO. N 105 Bruce St: ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	---	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed Registrar

C 10 1921

Robert P. Northrop

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1921

17

I HEREBY CERTIFY, That I attended deceased from December 2, 1921, to December 5, 1921, that I last saw him alive on December 5, 1921, and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tbc. meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

12/5/1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. Lot 2, Grave 1 Pendleton

DATE OF BURIAL Feb 10 1921

20 UNDERTAKER A. Jones

ADDRESS 2112 E. Monument

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 59265

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 School ST., 15 WARD)

2-FULL NAME Dorothy Booth

(a) RESIDENCE NO. 719 School ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Sept 28/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ....min.
	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Addie Booth

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Hallie Hamilton

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Hattie Booth
(Address) 719 School St

15 Filed ....19.... Robert T. Harrison, Registrar

Burial Permit Clerk.

C 10197

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1921, to Dec 7, 1921,

that I last saw her alive on Dec 6, 1921,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Fray, M. D.

(Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Dec 10 1921
20 UNDERTAKER Edward Ringgold	ADDRESS Lyceum

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59266

CERTIFICATE OF DEATH.

167

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hombo Spencer

(Residence in Baltimore: No. 1574 N Stricker St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Boy

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
3 yrs. ..... mos. ..... ds.	....hrs. or ....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Benj. Spencer,

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Hannah Spencer

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Spencer

(Address) 1574 N. Stricker St.

15-

Feb 21 1921, 191.....

Robert F. Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, general 1st degree

Hrs. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

....., 191.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Md. Auburn P. DATE OF BURIAL, Dec 9, 1920

20-UNDERTAKER Edward Ringgold ADDRESS 1463 Mary St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59267

CERTIFICATE OF DEATH.

REGISTERED No. C 6120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. Washington St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche D. Garrits

(Residence in Baltimore: No. 121 N Washington Pl St.; 36 yrs., 8 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, ~~WIDOWED, OR DIVORCED~~ (Write the word.) Yes Married

6-DATE OF BIRTH, April 5, 1885 (Month) (Day) (Year)

7-AGE, 36 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William F Thomas

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma C. Kramer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard A. Garrits

(Address) 1926 Madison Ave

15-

Robert P. Harrison,

Filed ....., 191.... Registrar.

REC'D 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1921, to Dec 10 1921,

that I saw her alive on Dec 10 1921,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

and Dropsy

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(Duration) ....yrs. ....mos. ? ds.

(Signed) Adolph E Eisenberg M. D.

Dec 12, 1921 (Address) 201 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Wood Lawn Cem	Dec 13th 1921
20-UNDERTAKER	ADDRESS
Joseph B Cook	503 N Bond St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 59268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59268

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 W. Franklin St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Hebbel

(a) RESIDENCE NO. 1828 W. Franklin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. C. W. Hebbel

6 DATE OF BIRTH (month, day, and year) Apr. 15" 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	60	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Mc Wain

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. L. Bates Etchison (Address) Reisterstown, Md.

15 Filed , 19 Robert J. Garrison, Registrar

DEC 10 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9" 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th 21 to Dec 9th 21, that I last saw h[illegible] alive on Dec 9th 21, and that death occurred, on the date stated above, at 12.30 noon m.

The CAUSE OF DEATH* was as follows:

Pregnancy Natural Valve Endocarditis Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Hebbel M. D.

19 22 (Address) 1507 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 12" 19 21

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N Calvert

Spec.—1-10-21—M&T—1500 Bks.

D 59269 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59269

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Mt. Royal Ave. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Talbott Jenkins

(a) RESIDENCE NO. 1424 Mt. Royal Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Francis X. Jenkins

6 DATE OF BIRTH (month, day, and year) March 25" 184[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel Md.
(State or country) Prince Georges County

PARENTS

10 NAME OF FATHER Thomas Jefferson Talbott

11 BIRTHPLACE OF FATHER (city or town) Howard Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Honora MacKenzie

13 BIRTHPLACE OF MOTHER (city or town) Howard Co.
(State or country) Md.

14 Informant Wilson Talbott Jenkins
(Address) 1424 Mt. Royal Ave.

15 Filed Dec 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8" 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1921, to Dec 8th, 1921, that I last saw her alive on Dec. 8th, 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Eugene Hughes, M. D.

Dec. 9" 1921 (Address) 800 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Dec. 10" 1921

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59270

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Willis

(a) RESIDENCE. NO. 731 Ajax St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Virginia

PARENTS

10 NAME OF FATHER John Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed DEC 9 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from December 7 1921 to December 8, 1921, that I last saw h. i.. alive on December 7, 1921, and that death occurred, on the date stated above, at 1:10 A.M. The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 6 mos. (?) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Clyde McNeill, M. D.

12/8/1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 11 1921
20 UNDERTAKER	ADDRESS
R C Gross & Co	McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59271

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Diggs

(a) RESIDENCE. No. 675 Pierce St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	(7) (1)	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed ..... 19 Robert P. Harriton, Registrar

Burial Permit Clerk.

DEC 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 1921

17

I HEREBY CERTIFY, That I attended deceased from November 30, 1921, to December 8, 1921, that I last saw h in alive on December 8, 1921, and that death occurred, on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yr. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? V. P. N. & Aut.

(Signed) Clyde Mitchell, M. D.

12/8/, 1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL: Dec 12 1921

20 UNDERTAKER: R C Gross ADDRESS: 1405 W Eldeer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Drum ✓

59272 D 59272

HEALTH DEPARTMENT—CITY OF BALTIMORE

59272 D 59272

CERTIFICATE OF DEATH.

X 10 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. R. St. Joseph's Hosp ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Walter Drum.

(a) RESIDENCE. NO. Woodstock ST.: Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs mos ds

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21. 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professor of

(b) General nature of industry, business, or establishment in which employed (or employer) Scripture

(c) Name of employer

9 BIRTHPLACE (city or town) Louisville
(State or country) Kentucky

PARENTS

10 NAME OF FATHER John Drum

11 BIRTHPLACE OF FATHER (city or town) Killeshandra
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Diamond

13 BIRTHPLACE OF MOTHER (city or town) Bandon
(State or country) Ireland

14 Informant John Drum
(Address) 73 Fremont & Baton Mass

15 Filed DEC 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1921

17 I HEREBY CERTIFY, that I attended deceased from Nov 25, 1921, to Dec 10, 1921, that I last saw him alive on Dec 10, 1921, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Contracted

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? York

Did an operation precede death? Date of Nov 25

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) F. C. Bramin, M. D.

19 (Address) 57 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodstock College Cem.	Dec. 13 1921

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59273

CERTIFICATE OF DEATH.

119 REGISTERED NO.

D 59273

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 314 Wesley st (ST.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Cain

(a) RESIDENCE. (No.) 314 Wesley St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs

6 DATE OF BIRTH (month, day, and year) — 1890

7 AGE 31 Years — Months — Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife 27

(b) General nature of industry, business, or establishment in which employed (or employer) Home Wife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore City

PARENTS

10 NAME OF FATHER William L Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md

14 Informant John Cain
(Address) 314 Wesley St

15 Filed DEC 11 1921 ROBERT J. KEATER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 23rd, 1921, to Dec 8th, 1921, that I last saw her alive on Dec 8th, 1921, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia bilateral
Nephritis and Cardiac
Dropsy

(duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) General exposure

+ Hardwork (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? urinary examination

(Signed) Edith Elliott, M. D.

, 19 (Address) 1626 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 11 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Philip Kirshner ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59274

CERTIFICATE OF DEATH.

10 D 59274

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Auburn Hosp. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Kirshner

(a) RESIDENCE. NO. 918 E Lafayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose R. Kirshner

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) 14th

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Kirshner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fortuta Kirshner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant David Kirshner (Address) 918 E. Fayette St.

15 Date DEC 11 1921 ROBERT S [illegible] Registrar Social [illegible] Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10 1921

17

I HEREBY CERTIFY, That I attended deceased from 11/24/21 19 . to 12/10/21 . 19 .

that I last saw him alive on 9:30 PM 12/10/21 19 .

and that death occurred, on the date stated above, at 9 AM m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Duodenal Ulcer

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

. 19 (Address) Mt Auburn Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edgewood Road.

DATE OF BURIAL: 12-11-21

20 UNDERTAKER: Jack Lewis

ADDRESS: 141 E Balto St

Bethew Osborn ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59275

CERTIFICATE OF DEATH.

175,001

D 59275

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bethel Osborn

(Residence in Baltimore: No. 407 W. Redwood a Kentucky a year St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1899 (Year)

7-AGE, 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sal
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), [illegible]

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Osborn

(Address) .....

15- DEC 11 1921 Filed ....., 191.... ROBERT J. KRAUSE Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Dec 8 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull
Cuts on head & face
not driving turned over Runaway
and Struck pavement

Duration: ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) A.C. Riley M. D.
Coroner

Dec 9, 1921. (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1)-MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hagood S. C.

DATE OF BURIAL, Dec 11, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59276

CERTIFICATE OF DEATH.

64

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 George ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes S. Brown

(Residence in Baltimore: No. 734 George St.; 33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Samuel Stewart

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lucy Ender Foster

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. L. Stewart

(Address) 734 George St

15-

Filed DEC 11 1921 ROBERT P. FOUTER

Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Friday Dec 9th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8th 1921, to Dec 9th 1921, that I saw h[illegible] alive on Dec 8th 1921, and that death occurred, on the date stated above, at 5 4 m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) .....yrs. .....mos. 2 ds.

(Signed) ..... M. D.

Dec 10th, 1921, (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec. 12, 1921

20-UNDERTAKER David Easter — ADDRESS 916 Eas[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59277

CERTIFICATE OF DEATH.

78 D 59277

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 N. Mount ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson

(a) RESIDENCE. No. 1010 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Johnson.

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Culpepper, Va.

PARENTS

10 NAME OF FATHER Nathan Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Culpepper, Va.

12 MAIDEN NAME OF MOTHER Bettie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Culpepper, Va.

14 Informant Frank Turner.
(Address) Culpepper, Va.

15 Filed DEC 11 1921 19 BOYER & SLATTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 - 1921

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1921, to December 10, 1921, that I last saw her alive on December 4, 1921, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Riland., M. D.

12-10 1921 (Address) 2532 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 12 1921
20 UNDERTAKER	ADDRESS
Daniel Carter	Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 59278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59278

CERTIFICATE OF DEATH.

64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 N. Broadway ST., 7 WARD)

2-FULL NAME Louis Lehr

(a) RESIDENCE NO. 700 N. Broadway ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Lehr

6 DATE OF BIRTH (month, day and year) Jan 3 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer 034

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harry L. Lehr (Address) 700 N Broadway

15 Filed DEC 11 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1921 to Dec 9 1921,

that I last saw him alive on Dec 8 1921,

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Coma

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Sage, M. D.

12/9 1921 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Dec 12 1921

20 UNDERTAKER Wm. Fickus & Sons — ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59279

CERTIFICATE OF DEATH.

64 D 59279

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2414 Edmondson Ave. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hahn

(a) RESIDENCE. No. 2414 Edmondson Ave. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Gottlieb Hahn

6 DATE OF BIRTH (month, day, and year): June 8-1852

7 AGE: Years 69 | Months 6 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Basle Switzerland

PARENTS

10 NAME OF FATHER: Joseph Reinle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Marion Schwind

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Mrs Lisa Werner
(Address) 2414 Edmondson ave

15 Filed DEC 11 1921 ROBERT R KRAFFT
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1921, to Dec. 8, 1921, that I last saw h alive on Dec. 7, 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cold & Congestion of lungs

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Marx, M. D.

(Address) 831 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Dec 12 1921

20 UNDERTAKER: F. A. Krause & Son — ADDRESS: 703 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59280

CERTIFICATE OF DEATH.

92 D 59280

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No Mercy Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Dora Snyder

(a) RESIDENCE. No. 2120 East Lombard ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Simon Snyder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Margolis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Union Snyder
(Address) 2120 East Lombard st

15 Filed DEC 11 1921 REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 30 1921, to Dec 11 1921,
that I last saw h[illegible] alive on Dec 11 1921,
and that death occurred, on the date stated above, at 3:20 pm.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. (2) mos. ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. ds.

18 Where was disease contracted Home
If not at place of death?

Did an operation precede death? Yes Date of Dec 7 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological Examination

(Signed) Jno F Gray, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL Dec 11 1921

20 UNDERTAKER Max Jemmon

ADDRESS Home Baltimore

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59281

CERTIFICATE OF DEATH.

120 D 59281

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 Wallbrook Ave 15 WARD)

2-FULL NAME Gertrude H Webb

(a) RESIDENCE NO. 1834 Wallbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of: Andrew J Webb

6 DATE OF BIRTH (month, day, and year): March 6 1844

7 AGE: Years 77 Months 8 Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Co Md

PARENTS

10 NAME OF FATHER: John C Vashell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Annall Lore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant: Harry H Webb

(Address): 1834 Wallbrook Ave

15 Filed DEC 1 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 21, to Dec 9, 19 21, that I last saw him alive on Dec 5, 19 21, and that death occurred, on the date stated above, at 1045 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William Tom Bryant M. D.

, 19 (Address) 1928 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Smyrna Delaware — DATE OF BURIAL: Dec 12 1921

20 UNDERTAKER: W Allain Cook — ADDRESS: 502 E Nath Ave

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 Harlem Ave. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaria Guglielizza

(a) RESIDENCE. 2907 Harlem Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Guglielizza

6 DATE OF BIRTH (month, day, and year) Jan 1 1857

7 AGE	Years	Months	Days
	64	11	

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Cortese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Guglielizza

(Address) 2907 Harlem Ave

15 Filed ..... 19 ..... Registrar

DEC 11 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1921 to Dec. 9, 1921, that I last saw h[er] alive on Dec. 8, 1921, and that death occurred, on the date stated above, at 9 45 P.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Tessy MD M. D.

12.10.21 , 19 (Address) Tom Wells - Buds

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 12 1921
20 UNDERTAKER	ADDRESS
William Ecol	502 E North Ave

Pisanyro—3146 Baltimore St—

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D 59283

REGISTERED NO. C

1-PLACE OF DEATH, CITY OF BALTIMORE (No.) Maryland Gen. Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George M Fry

(Residence in Baltimore: No. 340 East Federal St.; yrs. 50 mos. da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Retired 073
(b) General nature of industry, business, or establishment in which employed (or employer), Steel Road Engineer

9-BIRTHPLACE, (State or Country) York Co Pa

PARENTS.

10-NAME OF FATHER, Jacob Fry

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cadie H Fry

(Address) 340-E-Federal

15-

Filed DEC 11 1921, 191.. REGISTRAR

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Ruptured Appendix

(Duration) yrs. mos. 1 da.

(Signed) J. J. Hennessy M. D. (Coroner)

Dec 11, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westminster

DATE OF BURIAL, Dec 13, 1921

20-UNDERTAKER William Cook

ADDRESS 504 North

Dr J J Hennessy 2802 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 59284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59284

CERTIFICATE OF DEATH.

78

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 903 N. Bradford ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Pronek

(a) RESIDENCE. No. 903 N. Bradford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sonneborn

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Pronek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Emma Salerova

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frank Pronek

(Address) 903 N. Bradford St

15 Filed DEC 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 19 21, to Dec 5, 19 21, that I last saw h alive on Dec 7, 19 21, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Sputum

(Signed) I. S. Stamm, M. D.

Dec 7, 19 21 (Address) 1111 N. Bradford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odd Hill Cemetery	Dec 11 1921

20 UNDERTAKER Frank Brachbon. ADDRESS 1904 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Crocker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59285

CERTIFICATE OF DEATH.

21 D 59285

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) 4239 York Rd ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wister Crocker

(a) RESIDENCE. NO. 4239 York Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Merton

6 DATE OF BIRTH (month, day, and year) May 1, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer) 986

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Abraham Crocker

11 BIRTHPLACE OF FATHER (city or town) (State or country) State Vermont

12 MAIDEN NAME OF MOTHER Antonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant Wife - Florence Merton Crocker
Address 4239 York Rd.

15 Filed . 19 Registrar

DEC 1 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept . 1921 . to Dec 10 . 1921 .

that I last saw h[illegible] alive on Dec 10 . 1921 .

and that death occurred, on the date stated above, at [illegible] 10 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Course

(Signed) W. W. Wheaton . M. D.

. 19 (Address) 4231 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Md.	12/14/21 19
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E. North ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59286

CERTIFICATE OF DEATH.

91

D 59286

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 326 Dover St. St. 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Daily

(Residence in Baltimore: No. 326 Dover St

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colud

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 8, 1924
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. ....da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore city

PARENTS.

10-NAME OF FATHER, Henry Daily

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Edith Hawkins

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Daily

(Address) 326 Dover St

15-

Filed DEC 11 1924 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Cold

(Duration) ....yrs. ....mos. 3 ds.

(Signed) H. K. Gorsuch M. D.
(Coroner)

12-10, 1924. (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem Nov

DATE OF BURIAL, 12/11, 1924

20-UNDERTAKER Thos Scott & Son

ADDRESS 406 W. Lan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59287

CERTIFICATE OF DEATH.

78 D 59287

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1907 Brunt ST.: 14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Whiting

(a) RESIDENCE. NO. 1907 Brunt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw E. Whiting

6 DATE OF BIRTH (month, day, and year): May 23-1877

7 AGE: 44 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md Baltimore

PARENTS

10 NAME OF FATHER: — Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Dale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Murray Whiting
(Address): 1907 Brunt St

15 Date Received: DEC 11 1921 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 1921

17

I HEREBY CERTIFY, That I attended deceased from July, 1921, to Dec 8, 1921,

that I last saw h— alive on Dec-8-, 1921,

and that death occurred, on the date stated above, at 2 15 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cannot say

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Sputum.

(Signed) Edw Short, M. D.

12, 1921 (Address) 1512 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Dec 11 1921

20 UNDERTAKER: Saml Hendley — ADDRESS: Balto

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15-2507 D 59288 — 55-001 D 59288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No.) ST.: 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Rose Gray

(a) RESIDENCE. No. 2014 E. Eager ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-2-5

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Podjeska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed DEC 11 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-7, 1921, to 12-8, 1921, that I last saw her alive on 12-8, 1921, and that death occurred, on the date stated above, at 10:20 p m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis (Lethargic)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None.

(Signed) Horace G. Stewart, M. D.

12/9, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Dec 11 1921
20 UNDERTAKER	ADDRESS
Wm J. Hartley	815 N Howard St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59289

CERTIFICATE OF DEATH.

120 D 59289

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 Ashland ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Beck

(a) RESIDENCE. No. 2014 Ashland ST., ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mar'l	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Beck

6 DATE OF BIRTH (month, day, and year) July 4 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer himself

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Gruetty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Dorothy Beck (Address) 2014 Ashland ave

15 Filed DEC 11 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9-1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1921 to Dec 9 1921 that I last saw him alive on Dec 9 1921 and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Bright's disease
Nephritis. acute
Interstitial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma 9

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J F Ruppa M. D.

12-10-24 (Address) 800 N Patt Pl Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First United Evangelical Cem	Dec 12 1921

20 UNDERTAKER	ADDRESS
Wm C. Miller	2384 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. ~~Examples—Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.~~ The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis
Acute attack.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 59290

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3115 Walbrook Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Hudgins

(a) RESIDENCE. No. 3115 Walbrook ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia G. Hudgins

6 DATE OF BIRTH (month, day, and year) Feb 22 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) Sea Captain

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Matthews Co. Va

PARENTS

10 NAME OF FATHER Thomas L Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Billups

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Cornelia G. Hudgins
(Address) 3115 Walbrook Ave

15 Filed DEC 11 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9-1921

17 12-9-1921

I HEREBY CERTIFY, That I attended deceased from June, 1920, to Dec 9, 1921, that I last saw h[illegible] alive on Dec 9, 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia + Nephritis

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of Heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 3115 Walbrook Ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) A. H. McCulloch, M. D.

DH 10-9-21 (Address) 1415 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	DEC 12 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 59291

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST.: 7 WARD)

2-FULL NAME Thomas H. Johnson

(a) RESIDENCE. NO. 580 Oxford St. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Johnson

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Garage

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jacob Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Gibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Johnson (Wife) (Address) 580 Oxford St.

15 DATE RECEIVED DEC 11 1921

ROBERT E. SLATER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from August 4. 1921. to December 6 1921.

that I last saw him alive on December 6, 1921.

and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Lueta Infection

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical & Serological tests

(Signed) Dr. H. Edelmuth, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec. 11 1921
20 UNDERTAKER	ADDRESS
Jno. M. Johnson	1234 Ellwood Ave.

DE should be stated EXACTLY. PHYSICIANS should state
hat it may be properly classified. Exact statement of OCCUPA-
ns on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 26769 D

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1 Valley View Ave ST.; (No.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine R. Lauterbach

(a) RESIDENCE. NO. 1 Valley View Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 - 1921

7 AGE — Years — Months — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Lauterbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ethel M. Pierson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: William V. Lauterbach
(Address) 1 Valley View Ave

15 Filed DEC 12 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1921, to Dec 10, 1921, that I last saw her alive on Dec 10, 1921, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows: Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. Edw. Smith, M. D.

12/11, 1921 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: 12/12 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH LEAD PENCIL OR PEN AND INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59293

CERTIFICATE OF DEATH.

19 D 59293

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2824 Alameda ave St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Ott Jr.

(Residence in Baltimore: No. 2824 Alameda ave St.; 27 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Apr. 30 / 1894 (Month) (Day) (Year) 1

7-AGE, 27 / yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): Q.M.

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Henry Ott.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Matilda Popahn.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Ott

(Address) 2824 Alameda ave.

15-

Filed DEC 12 1921 [illegible] Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1921, to Dec 8 1921, that I saw him alive on 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Acute Malarian

(Duration) yrs. mos. da.

(Signed) A. G. Burdon M. D.

12/10, 1921 (Address) A. G. Burdon 2824 Alameda ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Schwartz — DATE OF BURIAL, Dec. 11, 1921

20-UNDERTAKER Wm. Cook. — ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1921
62
50 D 59294

D 59294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Singer Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Sarilla Garnet

(a) RESIDENCE NO. 7 Singer Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of James Garnet

6 DATE OF BIRTH (month, day, and year) Feb 14 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ord

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gotlieb Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Sarilla Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles B. Brooks

(Address) 2 Singer Ave

15 Filed DEC 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 1921 to Dec 10, 1921, that I last saw her alive on Dec 10 1921, and that death occurred, on the date stated above, at 1155 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis Diabetic Coma. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Numerous Symptoms

(Signed) C. D. Evans, M. D.

12-11, 1921 (Address) 2016 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 12/13 1921

20 UNDERTAKER William Cook — ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D 59295~~ 929 59295

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 N. Charles St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Wallace Gill

(a) RESIDENCE. No. 929 N. Charles St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced (or) WIFE of Late John Gill 2d

6 DATE OF BIRTH (month, day, and year) April 1st 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Wallace Spence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Ann Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va.

14 Informant (Address) A. H. S. 929 N. Charles

15 Filed DEC 12 1921 19 Registrar

MOSES S. KRAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th, 1921, to Dec 10th, 1921, that I last saw her alive on Dec 10th, 1921, and that death occurred, on the date stated above, at 10.50 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Hot Springs - Va

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) A. Duval Atkinson, M. D.

, 19 (Address) 1010 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 19
20 UNDERTAKER Henry W. Jenkins & Sons	ADDRESS Cathedral near Colleg

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 81

D 59296

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 N. Calvert ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Smith Pendleton Sr.

(a) RESIDENCE. No. ~~Same~~ Linwood Park, Md ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word): Married

5a If married, widowed or divorced HUSBAND of ~~(or WIFE of)~~ Jane Patterson Pendleton

6 DATE OF BIRTH (month, day, and year) Sept 18-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pay Master 073

(b) General nature of industry, business, or establishment in which employed (or employer): B+O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Philip P. Pendleton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Jane Leche

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: N. S. Pendleton

(Address): 1637 Royal Apts

15 Filed: DEC 12 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Decem 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1921, to Dec. 10, 1921, that I last saw h... alive on Dec. 9, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Uremia

(duration) from history - several yrs. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Linwood Park, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Brune C. Naylor, M. D.

Dec. 19 21 (Address) Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12-12 1921
20 UNDERTAKER: Henry W. Jenkins Sons Co	ADDRESS: McCulloh Orchard.

N. B.—WRITE PLAINLY, WITH LEAD PENCIL OR PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman*, (*b*) *Grocery; (a) Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage. No chronic heart trouble & No nephritis. No further history than asteno sclerosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59297

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 E 32nd St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emma Bosch

(a) RESIDENCE. No. 107 E. 32nd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16th 1889

7 AGE — Years: 32 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secretary & Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Ed. J. Rodell

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jacob Bosch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mathilde Krumm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Miss Emma Bosch (Address) 107 E. 32nd St.

15 Filed DEC 12 1921 19 [illegible] Registrar

[illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to Dec 10, 1921, that I last saw h alive on Dec 7, 1921, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Over

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Decomposition

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore H. Thomas, M. D.

19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 12 1921
20 UNDERTAKER	ADDRESS
Henry J. Jenkins & Son	Loch Raven & Belvedere

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No lues. No further history

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59298

CERTIFICATE OF DEATH.

79-091 D 59298

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 6 WARD)

2-FULL NAME Mary Deahields

(a) RESIDENCE. No. 1749 Aisquith ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Bayview Hospital (Address) Baltimore, Md.

15 Filed DEC 13 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9. 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1920 to Dec. 9. 1921

that I last saw h[illegible] alive on Dec. 8. 1921

and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. Hedenreich, M. D.

12/9/21 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL Dec. 12 1921

20 UNDERTAKER Mrs J. G. Locks

ADDRESS 1302 Gilmor

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 59299

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 1091 D 59299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 20 Overhill Road St., Roland Park 29 Ward.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Bachrach

(a) RESIDENCE No. 20 Overhill Road St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie K. Bachrach

6 DATE OF BIRTH (month, day, and year) July 16 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER David Bachrach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Hanstoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E. Kepper

(Address) 20 Overhill Rd Roland Pk

15 DEC 12 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5th, 1921, to Dec 10th, 1921, that I last saw him alive on Dec 10th, 1921, and that death occurred, on the date stated above, at 4 40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

Dec 11, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	12/12 1921
20 UNDERTAKER	ADDRESS
David Sondheim	1180 W. Mt. Royal Ave

N. B.—WHITE PAPER, WITH PINK MARGINS, FOR REGISTRATION. PINK PAPER, WITH WHITE MARGINS, FOR INFORMATION. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks. HELEN L. PUMPHREY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59300 — 184 D 59300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. Franklin Square Hospital 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Helen L Pumphrey -

(Residence in Baltimore: No. 1002 W Lexington St St.; 27 yrs., 10 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 15, 1894 (Month) (Day) (Year)

7-AGE, 27 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Felix Queenbourne

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER Miss Felicia Carey

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James G Pumphrey

(Address) 1002 W Lexington St

15- DEC 12 1921

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6- 1921, to to Dec 11 1921, that I saw h-r alive on Dec 11 1921, and that death occurred, on the date stated above, at 4:55 P.m.

The CAUSE OF DEATH* was as follows:

Abortion & Infection

(Duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Puerperal Septicemia

(Duration) — yrs. — mos. 3 ds.

(Signed) Henry C Wallace M. D.

Dec 11, 1921 (Address) Franklin Square Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 5 ds. In the State 27 yrs. 9 mos. 26 ds.

Where was disease contracted, if not at place of death? Resided 1002 W Lexington

Former or usual residence 1002 W. Lexington St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec 14, 1921
20-UNDERTAKER	ADDRESS
George J Schmick	1500 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Kuhn

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59301

CERTIFICATE OF DEATH.

120 ✓ D 59301

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1141 Lond ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celestina Kuhn

(a) RESIDENCE NO. 1141 Lond ST., 21 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Kuhn

6 DATE OF BIRTH (month, day, and year) Sept 2 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 -	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Labaus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Kuhn
(Address) 1141 Lond St

15 Filed DEC 12 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1921, to Dec 11, 1921, that I last saw her alive on Dec 10, 1921, and that death occurred, on the date stated above, at 2:00 p. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 1 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) [redacted] yrs. 6 mos. 2 ds.

18 Where was disease contracted, if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Edw Grunbaum, M. D.

12/12, 1921 (Address) 577 South Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 14 1921

20 UNDERTAKER John J. Fields ADDRESS 1200 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 59302

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 59302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 E Pratt ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Blumenthal

(a) RESIDENCE NO. 2021 E Pratt St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Blumenthal

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Morris Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Sachs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 Balto St

15 DEC 12 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1920, to Dec 11, 1921, that I last saw her alive on Dec 11, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2½ yrs. mos ds.

CONTRIBUTORY (Secondary) General Invasion resulting from Pulmonary Tuberculosis

(duration) One yrs. mos. ds.

18 Where was disease contracted if not at place of death?

DId an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Myer A Wembrow, M. D.

19 (Address) 1724 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rabbi Kenny Run	12-12 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Eugenia Posko

D 59303

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 59303 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 124 S. Wolf. ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Posko

(a) RESIDENCE. NO. 124 S Wolf ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fml

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 30, 1921

7 AGE Years: 10 Months: 10 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: HW

(b) General nature of industry, business, or establishment in which employed (or employer): HOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Jack Posko

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Agnes Blaboncz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Agnes Blaboncz 124 S Wolf St

Filed DEC 12 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Dec 10, 1921.

that I last saw h[illegible] alive on Dec 10, 1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Thyssen, M. D.

(Address) 80 N Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	Dec. 13 1921
20 UNDERTAKER	ADDRESS
M. J. Sadowski	705 S. Ann St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59304

CERTIFICATE OF DEATH.

151 D 59304

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 - 5 - Durham ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ramond Rutkowski

(Residence in Baltimore: No. 723 - 5 - Durham St.; — yrs., — mos. 1/2 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, ~~MARRIED~~, WIDOWED, OR ~~DIVORCED~~, (~~Write the word.~~) Single

6-DATE OF BIRTH, 12 (Month) 10 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. Edword Rutkowski

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Pauline Sierwerski

13-BIRTHPLACE OF MOTHER (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edword Rutkowski

(Address) 723 S. Durham St

15-

Filed DEC 12 1921 [illegible]

Burial Permit Issued [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I saw h... alive on ..... 191...,

and that death occurred, on the date stated above, at 2^m. m.

The CAUSE OF DEATH* was as follows:

Asthma

6 1/2 month fortus

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) 6 1/2 months fortus

(Duration) — yrs. — mos. — ds.

(Signed) J. J. McCardell M. D.

12/12/21 (Address) 633 - S - 3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus, Bcm

DATE OF BURIAL, Dec 12, 1921

20-UNDERTAKER M. F. Sadowski

ADDRESS 705 S. Ann St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59305

CERTIFICATE OF DEATH.

9 D 59305

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Staskunas

(a) RESIDENCE. No. 906 East Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mrs Staskunas

6 DATE OF BIRTH (month, day, and year) DEC 25 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mercy Hospital Records

15 Filed DEC 12 1921, 19 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 10 1921

17 I HEREBY CERTIFY, That I attended deceased from DEC 3, 1921, to DEC 10, 1921, that I last saw h[illegible] alive on DEC 10, 1921, and that death occurred, on the date stated above, at 2.35 P.M.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr. Symptoms

(Signed) Paul L. Carter M. D.

, 19 (Address) Upton, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	12/13 1921

20 UNDERTAKER J. Jankowski

ADDRESS 427 Pond

D 59306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59306

CERTIFICATE OF DEATH.

79

REGISTERED NO. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. ~~Pa~~ Pratt & Market Space, ~~Color~~ Cor. Colvin ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Winder

(Residence in Baltimore: No. 1116 Druid Hill Av St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) ..., 1877 (Year)

7-AGE, 44 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, James Winder

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Fanny Harris

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Winder

(Address) 1116 Druid Hill Ave

15- DEC 12 1921 BUREAU OF VITAL STATISTICS

Filed ..., 191... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 8, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulm. Hem. Heart

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arth. Chronic Endocarditis

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. (Coroner)

Dec 10, 1921 (Address) 1137 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec. 12 1921

20-UNDERTAKER Frank T. Hensley ADDRESS 678 Mad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59307

CERTIFICATE OF DEATH.

H5 D 59307

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Ashland Ave St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Byrd

(Residence in Baltimore: No. 1235 Ashland Ave St.; 5 yrs., ~ mos., ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August 7, 1860 (Month) (Day) (Year)

7-AGE, 61 yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~None~~ None
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country) Carolina Co. Va.

PARENTS.

10-NAME OF FATHER, Wm Fox

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Jane Harris

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Wilson

(Address) 1239 Ashland Ave

15-

Filed DEC 12 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1921, to Dec 8 1921, that I saw her alive on Dec 1 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bowels

(Duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(Duration) 1 yrs. 7 mos. ~ ds.

(Signed) R B Kenyon M. D.

Dec 9, 1921 (Address) 611 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Asbury Cem — DATE OF BURIAL, Dec 12, 1921

20-UNDERTAKER Samuel T Hemsley — ADDRESS 518 N Eddlestone

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59308

CERTIFICATE OF DEATH.

9 D 59308

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Lancaster ST.: W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Paz.

(a) RESIDENCE. No. 1713 Lancaster ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 22 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Valenty Paz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER May Demotlotte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Valenty Paz.
(Address) 1713 Lancaster

15 Filed ..... 19.... Registrar

DEC 12 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 10, 1921, that I last saw h— alive on Dec 10, 1921, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Wharton, M. D.

(Address) Harlem Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	12/13/21
20 UNDERTAKER	ADDRESS
Wm Fairfowl	1618 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Holshauser

D 59309 HEALTH DEPARTMENT—CITY OF BALTIMORE 191 D 59309

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED No. C.....

CITY OF BALTIMORE: (No. Rm 2 Veterans Hospt ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary Holshauser.

(Residence in Baltimore: No. 1847 West Fayette. St.: 44 yrs., 7 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, April 21, 1877 (Month) (Day) (Year)

7-AGE, 44 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): D.3

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thos Gallagher

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary A Considine

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno A Holshauser

(Address) 1847 W Fayette

15- DEC 12 1921

Filed....., 191.... J.H.Wilson Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 11, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1921, to Dec. 11 1921, that I saw h.. alive on Dec. 10 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Uraemia

Myocarditis.

Broncho Pneumonia.

(Duration) 3 plus yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia & Br Pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) D. Lloyd Johnson M. D.

Dec. 11, 1921. (Address) Bon Secours Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State 44 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1847 W Fayette St

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL. 12/14, 1921.

20-UNDERTAKER George A Farley ADDRESS Sutton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59310

D 59310

HEALTH DEPARTMENT—CITY OF BALTIMORE

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Cole St. St.: 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R Campbell

(a) RESIDENCE. No. 1727 Cole St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John J Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Nora Fleck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Wife of Cole St.

(Address)

15 Filed DEC 12 1921 Registrar H E Helm

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec Oct 16 1921, to Dec 10; 1921, that I last saw her alive on Dec 9, 1921, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

Persistant Thymus.

(duration) yrs. 1 mos. 26 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Edw F Coleman M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/12/1921
20 UNDERTAKER George W Fuhrman	ADDRESS 7 Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Pettilli)

D 59311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 | D 59311

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 304 E 7th St. 26 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Pettilli

(Residence in Baltimore: No. 304 E 7th St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, August 29, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS:

10-NAME OF FATHER, Luca Pettilli

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Passano

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Pettilli

(Address) 304 E 7th St

15-

Filed ....., 191.... Registrar.

DEC 12 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Investigation find that said deceased came to Le death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None Found

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Lucas Grant M. D.
(Coroner)

12/12, 1921 (Address) 800 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Thomas Cem	Dec 13 1921
20-UNDERTAKER	ADDRESS
J Perring & Co	2008 Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59312

CERTIFICATE OF DEATH.

69

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 321 N. Hay ST.: 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edwin Grove

(Residence in Baltimore: No. 321 N. Hay St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH, Unknown, (Month) (Day) 1906. (Year)

7-AGE, 15 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Hagerstown

PARENTS.

10-NAME OF FATHER, — Grove

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Bertha Grove

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry F. Bucher

(Address) 321 N. Hay

15- DEC 12 1921 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Epileptic Convulsion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(Duration) yrs. mos. ds.

(Signed) W. J. Riley (Coroner.) M. D.

Dec 11, 1921 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hagerstown Md — DATE OF BURIAL, Dec 14, 1921

20-UNDERTAKER E J Lannigan & Son — ADDRESS 1935 E Lafayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59313

CERTIFICATE OF DEATH.

120 D 59313

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 71 WARD)

2-FULL NAME Margaret Grill

(a) RESIDENCE. No. Unknown 1003 Bayard ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
87	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed DEC 12 1921, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from December 7, 1921, to December 8, 1921, that I last saw her alive on December 8, 1921, and that death occurred, on the date stated above, at 9:55 P. M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Clyde McNeil, M. D.

12/9/, 1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec.12 1921
20 UNDERTAKER	ADDRESS
E.I.Fanning&Son	1460 Battery Ave.

MAJOR should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 59314

HEALTH DEPARTMENT—CITY OF BALTIMORE

(1521) 59314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 E Monument St., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll. R. Sumner Jr.

(a) RESIDENCE NO. 2015 E Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11-1921

7 AGE	Years	Months	Days	If LESS than 1 day old 24 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Carroll R. Sumner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Helen Veronica Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Carroll Edward Sumner

(Address) 2015 E Monument

15 Filed DEC 12 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1921, to Dec 12, 1921, that I last saw h[illegible] alive on Dec 11, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema due to Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward L. Cook M. D.

(Address) 4137 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	Dec 12 1921
20 UNDERTAKER	**ADDRESS**
Geo M. Troth & Son	811 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59315

D 59315

30

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, St.: 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hall

(a) RESIDENCE. No. 509 N. Fremont St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ? Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Record

15 Filed DEC 12 1921

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11- 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-4, 1921, to 12-11, 1921, that I last saw h[illegible] alive on 12-11, 1921, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis,

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cem	Dec 14 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Lewis Hillman

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59316

CERTIFICATE OF DEATH.

15 / D 59316

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 E. Gettings ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence L Gergens

(a) RESIDENCE. No. 507 E Gettings ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Carroll E Gergens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Viola Wentworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Minnie Wentworth
(Address) 507 E Gettings St

15 Filed DEC 12 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/16 1921, to 12/11 1921, that I last saw h alive on 12/11 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Mal nutrition from Birth

(duration) ... yrs. 25 mos. ... ds.

CONTRIBUTORY (Secondary) Due to Lues + Syphilis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. J. Dunlington, M. D.

19 (Address) 107 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill — DATE OF BURIAL Dec 12 1921

20 UNDERTAKER John H Denny — ADDRESS, 115 Light

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D 59317

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Gen. Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie E. McCoy

(a) RESIDENCE. NO. 1906 McHenry Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1850

7 AGE: Years 71 Months 3 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Matron

(b) General nature of industry, business, or establishment in which employed (or employer): Balto Day Nursery

(c) Name of employer: Balto Inca

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Cassandra Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs L P Hammack
(Address): Owings Mills Md

15 Filed DEC 12 1921 19 [illegible] Registrar
Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 1921 to Dec. 10 1921, that I last saw her alive on Dec. 10 1921, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Gangrenous Appendicitis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Peritonitis, acute.

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Dec. 9, 1921

Was there an autopsy? yes.

What test confirmed diagnosis? Culture from peritoneal fluid.

(Signed) Joseph P Kerby, M. D.

, 19 (Address) South Balto. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Dec 13 1921

20 UNDERTAKER: John F Downey

ADDRESS: 715 Light St

MARRIAGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

59318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

OD 59318

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 18 S. Streeper ST.: 6 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Leick

(a) RESIDENCE. No. 18 S. Streeper ST., WARD. 6.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. 4 ds. 16 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of or WIFE of: John F. Leick

6 DATE OF BIRTH (month, day, and year): July 25 1866

7 AGE: Years 55 Months 4 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Peter Adler.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Frederika Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): John F. Leick Westminster Md

15 Filed . 19 [illegible] Registrar

DEC 12 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Dec. 10, 1921, that I last saw h[illegible] alive on Dec 9, 1921, and that death occurred, on the date stated above, at 3 P M, m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo D Dwyer, M. D.

, 19 (Address) 28, 8 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec. 14 1921
20 UNDERTAKER: Zinkler & Zinkler Bros.	ADDRESS: 1739 E. Eager St

SHOULD be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59319 ✓ 9 D 59319

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 S. Clinton St ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Anna Brooks.

(a) RESIDENCE. NO. 1133 S. Clinton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 29—1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child nos

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Brooks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant William Brooks.
(Address) 1133 S. Clinton St.

15 Filed , 19 Robert P. Harrison, Registrar
C 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921, to Dec 11, 1921, that I last saw her alive on Dec 11, 1921, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Diptheria (Laryngeal)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) asphyxia + toxemia

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. F. W. Wright, M. D.

Dec 11, 1921 (Address) 1014 S. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Dec 13 1921
20 UNDERTAKER Lilly & Feiler	ADDRESS 403 N. Howard St.

be stated EXACTLY. PHYSICIANS should state
ay be properly classified. Exact statement of OCCUPA-
k of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59320

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Hanley ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Raymach

(a) RESIDENCE. No. 2225 Hanley ST., 6 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Virginia Boyd

6 DATE OF BIRTH (month, day, and year) 1885 April 12

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Latherer

(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturer

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Joseph Raymach

11 BIRTHPLACE OF FATHER (city or town) Kolne
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Barbara Shimek

13 BIRTHPLACE OF MOTHER (city or town) Klatove
(State or country) Bohemia

14 Informant Frances Emanuel
(Address) 1715 E. Pratt St.

15 Filed ..... 19.... Robert P. Harrison, Registrar

DEC 12 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1921, to Dec 11, 1921, that I last saw h.... alive on Dec 10, 1921, and that death occurred, on the date stated above, at 2:05 A.m.

The CAUSE OF DEATH* was as follows:

Pyaemia Abscess

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hospital

Did an operation precede death? Yes Date of Nov 25

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Alfred A. Bandeck, M. D.

, 19 (Address) 8 E. Pattison Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 13 1921
20 UNDERTAKER Leo L Cook	ADDRESS North Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59321

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Kresmia)

CERTIFICATE OF DEATH.

64 D 59321

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1604 Shakespeare ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Kresmia

(Residence in Baltimore: No. 1604 Shakespeare St St.; yrs., 29 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 11, 1

(Month) (Day) (Year)

7-AGE. 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Co

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Wiley

(Address) 916 E. Fayette

15-

Filed DEC 1 1921

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1921

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Fenn M. D.

(Coroner)

Dec 13, 1921 (Address) 1501 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Dec. 14, 1921
20-UNDERTAKER	ADDRESS
Frank Everhart Son	916 Eastlanda

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 59322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59322

CERTIFICATE OF DEATH.

152

Johns Hopkins Hospital

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby of Katie Moorehead

(a) RESIDENCE NO. 2013 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 16 hrs. or 55 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Jesse Moorehead

11 BIRTHPLACE OF FATHER (city or town) Miss.
(State or country)

12 MAIDEN NAME OF MOTHER Katie Marshall

13 BIRTHPLACE OF MOTHER (city or town) Ky
(State or country)

14 Informant Johns Hopkins Hospital
(Address) Baltimore

15 Filed DEC 12 1921, 19 Robert P. Bertram Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1921, to Dec 3, 1921,

that I last saw her alive on Dec. 3, 1921,

and that death occurred, on the date stated above, at 6 55 m.

The CAUSE OF DEATH* was as follows:

Intracranial haemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Cathcart, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Dec 1921, 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59323

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Quarles

(a) RESIDENCE. No. 714 Bevan St ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 140

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Festus Quarles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital.

15 DEC 12 1921, 19 Robert F. Karrlbent, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1921, to December 9, 1921, that I last saw him alive on December 8, 1921, and that death occurred, on the date stated above, at 12:45 A. M.

The CAUSE OF DEATH* was as follows:

Syphilitic aortic insufficiency

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Was.

(Signed) Clyde McNeill, M. D.

12/9/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59324

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Prusack.

(a) RESIDENCE. NO. 3201 Elliott ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day 20 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Josephs Hospital
(State or country)

PARENTS

10 NAME OF FATHER Joseph J Prusak.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Fitz

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Canada

14

Informant
(Address) Robert F. Harrison,

Filed 5/12 1921 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9/ 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Dec 9, 1921, that I last saw him alive on Dec 9, 1921, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. M. Freeman, M. D.

, 19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59325 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1022 Vine St. 18 WARD) REGISTERED NO. C 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Brown

(Residence in Baltimore: No. 1022 Vine St. St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec, 1885
(Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Neal

(Address) 1022 Vine St

15-

Filed DEC 12 1921 Robert P. Harrison Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF ~~DEATH~~, Dec 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. ds.

(Signed) C. C. Slade M. D.
(Coroner.)

Dec 9/21 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Dec 12, 1921

20-UNDERTAKER Bronx Freeland — ADDRESS 1405 E Balto St

NB—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59326

HEALTH DEPARTMENT—CITY OF BALTIMORE

8 / D 59326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2301 Edmondson Ave. St.: 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Faulk Woodward

(a) RESIDENCE. No. 2301 Edmondson Ave. St., 20 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Pearce Woodward

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

PARENTS

10 NAME OF FATHER Geo. Faulk,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Penna.

12 MAIDEN NAME OF MOTHER Ursula Paulding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Penna.

14 Informant Chester P. Woodward.
(Address) 2800 Edmondson Ave

15 Filed Dec 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from October, 1919, to December, 1921, that I last saw her alive on December 10, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion (Heart weakness)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Hard. Arteries) (duration) 2 yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chester P Woodward, M. D.

Dec 11 1921 (Address) 2800 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Dec. 14. 1921

20 UNDERTAKER Geo W Lulle ADDRESS 2700 Edmondson ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59327

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH West End Maternity Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 112 N Calhoun ST., 19 WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Murkey

(a) RESIDENCE No. West End Maternity Hospital. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 12 12. 21

7 AGE	Years	Months	Days	If LESS than 1 day 17 hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 400

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) West End Maternity Hospital 112 N Calhoun St Balto

PARENTS

10 NAME OF FATHER Chas. A Murkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Mary A Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Charles A Murkey
(Address) 822 N. Monroe St.

15 Dec 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1921, to Dec 12, 1921, that I last saw h alive on Dec. 12, 1921, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(8 mos Uterine Gestation)

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? History of Case

(Signed) Jane Brown, M. D.

Dec 12 1921 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec. 13 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1603 N Eutaw St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59328

CERTIFICATE OF DEATH.

92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3040 Cedar Ave. ST.: 13 WARD)

2-FULL NAME Anna Smith

(a) RESIDENCE. NO. 3040 Cedar Ave ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Smith

6 DATE OF BIRTH (month, day, and year): Feb. 26-1861

7 AGE — Years: 60 — Months: 9 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Maryland

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary Dix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant: Mrs. Blanche C. Sewell
(Address) 3351 Chestnut Ave

15 Filed 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

12 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921, to Dec 12, 1921, that I last saw her alive on Dec 12, 1921, and that death occurred, on the date stated above, at 5 05 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure
Senile
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Labor Pneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. A. Pinkerton M. D.

Dec 12 1921 (Address) 1124 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Mary's (Hampden)	Dec. 14 1921

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Rd

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Matthews)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59329 — D 59329

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 Penn ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie V Matthews

(a) RESIDENCE. NO. 110 Penn ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John H. Matthews

6 DATE OF BIRTH (month, day, and year) May 7 61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant [illegible]
(Address) 1705 St Paul

15 Filed DEC 12 1921, 19 Registrar
Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 1921 to Dec 10th 1921, that I last saw he alive on Dec 10th 1921, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Kenneth Williams, M. D.

, 19 (Address) 611 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Fulton	Dec 14 19 21
20 UNDERTAKER	ADDRESS
Benj. H. Clark Sons	1700 Mad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

(Darr)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59330

15249 59330

CERTIFICATE OF DEATH.

X 120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. St.; 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Parr

(a) RESIDENCE. No. Raleigh St., Ward. (Raleigh N. C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Roberta

6 DATE OF BIRTH (month, day, and year) 6-14-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Obediah Parr

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Jane Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed DEC 1 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-9, 1921, to 12-11, 1921, that I last saw h alive on 12-11, 1921, and that death occurred, on the date stated above, at 9 45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis - uremia.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical symptoms

(Signed) Edwin Bowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh N C	Dec 13 1921
20 UNDERTAKER	ADDRESS
Jas. H. Chandler	1400 Mad

I.B.—WRITE PLAINLY with pen and ink—and use no abbreviations. All the items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59331

CERTIFICATE OF DEATH.

32 D 59331

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 S. Gilmor (ST.) 19 (WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Morley

(Residence in Baltimore: No.) 111 S. Gilmor (St.) Life (yrs.) (mos.) (ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Apr. (Month) 1 (Day), 1861 (Year)

7-AGE.	If LESS than 1 day,
60 yrs. 8 mos. 9 ds.	...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER, Perry Morley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellen Mullineax

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lotus Morley

(Address) 111 S. Gilmor St.

15-

Filed Robert. F. Harrison, Registrar.

12 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Dec 10 1921, that I saw him alive on Dec 9 1921, and that death occurred, on the date stated above, at 8-30 A. m.

The CAUSE OF DEATH* was as follows:
Pott's disease of spine with abscess
Causing Paraplegia (Tuberculosis)

(Duration) Yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. 1 mos. ds.

(Signed) Henry C. Wilke M. D.

Dec. 10, 1921. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Dec 13, 1921

20-UNDERTAKER Harry H. Wilke

ADDRESS, 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59332

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D 59332

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 620 W. Lafayette St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine H. Payne

(Residence in Baltimore: No. 620 W. Lafayette ave. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Nov. 14, 1874
(Month) (Day) (Year)

7-AGE, 47 yrs. 6 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Flagg

(Address) 620 W. Lafayette ave.

15-

Filed..... Robert P. Harrison, Registrar.

DEC 12 1921 Burial Permit Clerk

P. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held no inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.
(Coroner)

Dec. 12, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem.

DATE OF BURIAL, Dec 13, 1921

20-UNDERTAKER George H. Holland

ADDRESS 1631 Linden Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59333

CERTIFICATE OF DEATH.

92 D 59333

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Ware ST. 17 WARD)

(If death occurred in a hospital ur institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Brooks

(a) RESIDENCE. NO. 211 Ware ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Sam Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Brooks
(Address) 211 Ware St

15 Filed ..... 19.. Robert F. Harrison, Registrar
[illegible] Permit Clerk.

C 12 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 10, 1921, that I last saw h[illegible] alive on Dec 10, 1921, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Richardson, M. D.

Dec 10, 1921 (Address) 1124 N. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cmty	Dec 14 192[illegible]

20 UNDERTAKER: George H. Holland ADDRESS 1631 D. Hill

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1845 Preston St. 15 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elzi Paist

(a) RESIDENCE. No. 1845 Preston St., Ward.

(Usual place of abode) whole life

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced (or) WIFE of Chas. Milton Paist

6 DATE OF BIRTH (month, day, and year) Feb. 9-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer) General house work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Chas. B. Coser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Lenora Bilger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md.

14 Informant Chas. Milton Paist

(Address) 1845 Preston St.

15 Filed ....., 19 Robert P. Harrison, Registrar

DEC 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11- 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to Dec. 10, 1921, that I last saw h[illegible] alive on Dec. 10, 1921, and that death occurred, on the date stated above, at 10-31 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum test

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 906 N. Strieker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Dec 14th 1921
20 UNDERTAKER Bertram L. York	ADDRESS 1729 W. Lafayette Ave

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 59335

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D 59335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 14 East Woodland Ave St. 27 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sally Elizabeth Johnson.

(a) RESIDENCE. No. 14 East Woodland Ave St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James F Johnson

6 DATE OF BIRTH (month, day, and year) Aug 14 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cocomoke Somerset Co Md.

PARENTS

10 NAME OF FATHER Tull.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co

12 MAIDEN NAME OF MOTHER Eliza. Powell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co

14 Informant Herman Parks.
(Address) 14 E Woodland Ave.

15 Filed DEC 1 1921 19 Robert F. Harrison, Registrar

Burial Permit Clerk

M & O U. R.R. Herman Parks.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to Dec 11, 1921, that I last saw her alive on Dec 11, 1921, and that death occurred, on the date stated above, at 6 o'clock a m.

The CAUSE OF DEATH* was as follows:

(Chronic Intestinal Stasis)
(Inanition)

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) (Fibroid tumor)

(duration) 6 or 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr A. E. Spencer, M. D.

, 19 (Address) 6 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pocomoke Md	Dec 13 1921.

20 UNDERTAKER ADDRESS

William Cook & Sons 526 W Lanvale St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59336

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 546 Robert ST.: 14 (WARD)

2-FULL NAME Sarah Gould

(a) RESIDENCE. No. 546 Robert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Queen Anne's Md

PARENTS

10 NAME OF FATHER Phillip Royal

11 BIRTHPLACE OF FATHER (city or town) Queen Anne Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Emburn

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary E Ross
(Address) 546 Robert St

15 DEC 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1921, to Dec 10, 1921, that I last saw h alive on Dec 9, 1921, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Organic Heart Disease (Mitral Insufficency) 2 yrs. mos. ds.
(duration)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jane Broom, M. D.

Dec 10, 1921 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	12/13/21
20 UNDERTAKER	ADDRESS
Julius B Rye 102 E.	Mulberry St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59337

CERTIFICATE OF DEATH.

154 D 59337

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 2571 Frederick Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Durham

(a) RESIDENCE. NO. 2571 Frederick Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Columbus Durham

6 DATE OF BIRTH (month, day, and year) July 14-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Mathias Haupt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary E Hobeck
(Address) 2571 Frederick Ave

15 DEC 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1921, to Dec 12, 1921,

that I last saw her alive on Dec 11, 1921,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grantham M. D.

12.12.21 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 14 1921
20 UNDERTAKER	ADDRESS
H D Hepperd	2336 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59338

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40

D 59338

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1012 Whitmore ave ST. 16 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louisa Wiseman

(Residence in Baltimore: No. 1012 Whitmore Ave St.; 73 yrs. 5 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 [redacted] (If married, widowed or divorced): Indow

6 DATE OF BIRTH: May 12th, 1848 (Month) (Day) (Year)

7 AGE: 73 yrs. 5 mos. 28 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer): Housewife 000

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Preston Leister

(Address) 1012 Whitmore ave

15. Filed DEC 13 1921 [redacted] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 10 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23, 1921, to Dec 9, 1921, that I saw h[illegible] alive on Dec 9, 1921, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Gastritis

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY) Carcinoma of Stomach

(Duration) 1 yrs. 4 mos. ds.

(Signed) Louis Munro M. D.

Dec 11, 1921 (Address) 1724 Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. — In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec 13, 21

UNDERTAKER: F. D. Kappert — ADDRESS: 2336 Fred'k ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59339

CERTIFICATE OF DEATH.

64

D 59339

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 3. W. Biddle (St.) 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Winder

(a) RESIDENCE. No. 3. W. Biddle St St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas F. Winder

6 DATE OF BIRTH (month, day, and year): August 10th 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Alicia McClair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edward Lloyd Winder

(Address): 3 W. Biddle St.

15 Filed DEC 13 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8th, 1921, to Dec 12th, 1921, that I last saw her alive on Dec 12th, 1921, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) H. H. Blodgard, M. D.

12/22, 1921 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wye House-Easton Talbot Co. Md.	12-13 1921

20 UNDERTAKER: Henry J. Jenkins Funeral Home Co

ADDRESS: W. Fallsway & Orchard

TION is very important. See instructions on back of certificates.

D 59340

Spec. 629 N. H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59340

CERTIFICATE OF DEATH.

REGISTERED NO. 102

1-PLACE OF DEATH Municipal Hosp.

CITY OF BALTIMORE: (No.) ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wilson

(a) RESIDENCE. NO. 14 East St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of F. Wilson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 31; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Dept. Records

(Address)

15 Filed DEC 13 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 1921 to Dec 10 1921

that I last saw h[illegible] alive on Dec 10 1921

and that death occurred, on the date stated above, at .m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer OVER

Gastric (duration) 2 yrs, [illegible] ds.

CONTRIBUTORY (Secondary) Lymphosarcoma (duration) yrs. mos. 27 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Clyde Moore, M. D.

12-11 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Dec 13 1921

20 UNDERTAKER: John W Henderson & Monument — ADDRESS 1502

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59341

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH 1480 Jackson Court — REGISTERED NO.

CITY OF BALTIMORE: (No. 1430 Jackson Ct ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Holden

(a) RESIDENCE. NO. 1430 Jackson ST. Court WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 54 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 837

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N J Liv in Baltimore 20 years

PARENTS

10 NAME OF FATHER Elijier Drury

11 BIRTHPLACE OF FATHER (city or town) (State or country) N J

12 MAIDEN NAME OF MOTHER Adline Drury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N J

14 Informant Charley Holdden
(Address) 1430 Jackson Court —

15 Filed DEC 13 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 30th, 1921, to Dec 10th, 1921, that I last saw h[illegible] alive on ' ', 1921, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wessner, M. D.

12/13 1921 (Address) 30 S B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 13 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59342

59342

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Lewis ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Henry Lewis

(a) RESIDENCE. No. 405 Lewis ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25 192[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore born in Baltimore

PARENTS

10 NAME OF FATHER Thos Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Ella Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Ellie Lewis
(Address) 405 Lewis St

15 Filed DEC 13 1921 [illegible] Registrar

Burial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 19[illegible]

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 19[illegible], to Dec 11, 19[illegible], that I last saw him alive on Dec 11, 19[illegible], and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
Primary Cause

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Clyde Burns, M. D.

12-15-21, 19 (Address) 2218 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 13 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59343

CERTIFICATE OF DEATH.

81 D 59343

1-PLACE OF DEATH Emerson Park REGISTERED NO.

CITY OF BALTIMORE: (No. 3710 Ashburton Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Smith

(a) RESIDENCE No. 3710 Ashburton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Smith

6 DATE OF BIRTH (month, day, and year) June 18 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Valentine Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Mund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Smith (Address) 3710 Ashburton Ave

15 Filed DEC 13 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1921 to Dec 11 1921 that I last saw h[illegible] alive on Dec 7 1921 and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows: Uremia Sclerosis 2 DTW

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) [illegible] M. D.

12-12 1921 (Address) 1405 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 3 1921
20 UNDERTAKER	ADDRESS
W. J. Gardner & Sons	Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

D. Byers
Edinburgh Scot
Not Calhoun St
No hemorrhage or apoplexy
No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59344

CERTIFICATE OF DEATH.

D 59344

REGISTERED NO. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Koehler

(a) RESIDENCE. NO. 1820 Bolton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1921

7 AGE: Years — Months — Days 2 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Clarence Koehler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Bessie Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Clarence Koehler

(Address) 1820 Bolton St.

15 DEC 13 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921, to Dec. 12, 1921.

that I last saw her alive on Dec 12, 1921,

and that death occurred, on the date stated above, at 6:05 P. m.

The CAUSE OF DEATH* was as follows:

Achondroplasia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Patent foramen ovale

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Examinations

(Signed) John L. Evans, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — DATE OF BURIAL: Dec. 13 1921

20 UNDERTAKER: Lilly and Zeller — ADDRESS: 403 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

091

X 50 D 59345

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Woman's Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Dunnington Davis

(a) RESIDENCE NO. Woman's Hospital ST., ... WARD ..... (Torrson-Md)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? 63 yrs. 3 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A Davis

6 DATE OF BIRTH (month, day, and year) Sept-7-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER Alexander Gould

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah Dennington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles A. Waters

(Address) 1100 N. Charles St. Balto Md

15 Filed DEC 13 1921 16 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921, to Dec 11, 1921,

that I last saw her alive on Dec 11, 1921,

and that death occurred, on the date stated above, at 4 15 p m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E E Duncan, M. D.

12/11, 1921 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Grove Mo'dry. Carroll Co. Md — DATE OF BURIAL: Dec/13/1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D 59346~~ 8ND 59346

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Apts ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide Rebecca Laughlin

(a) RESIDENCE. NO. Homewood Apts ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wylie Laughlin

6 DATE OF BIRTH (month, day, and year) About 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Henry Hausewald

11 BIRTHPLACE OF FATHER (city or town) not known
(State or country) Germany

12 MAIDEN NAME OF MOTHER Adelaide Detrich

13 BIRTHPLACE OF MOTHER (city or town) not known
(State or country) Germany

14 Informant Mrs. R. B. Laughlin (Brother-in-Law)
(Address) 1702 Eutaw Place

15 Filed DEC 13 1921 BOYCE E. PORTER Registrar (Actg.) Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1921, to Dec 11, 1921, that I last saw her alive on Dec 10, 1921, and that death occurred, on the date stated above, at 8:15 p. m.

The CAUSE OF DEATH* was as follows:

Heart embolism

(Death was instantaneous)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration several yrs.) mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr C. R. Deuker, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 13 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59347

CERTIFICATE OF DEATH.

79 D 59347

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1812 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline M Wright

(a) RESIDENCE. No. 1812 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo A White

6 DATE OF BIRTH (month, day, and year) Jan. 2 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer Self Ga

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sarah Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geo A White
(Address) 1812 McCulloh

15 Filed DEC 13 1921 . 19 [illegible] Registrar [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to Dec 11, 1921.

that I last saw her alive on Dec 11, 1921.

and that death occurred, on the date stated above, at 11.40 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency + Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Carried for,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope

(Signed) Edw Shorb, M. D.

12/7/1921 (Address) 1812 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 14 1921

20 UNDERTAKER Samuel S Hemsley ADDRESS 1718 N Bidd St

MARRIED WOMEN: Should be called by married name. AGE: Should be stated EXACTLY. PHYSICIANS: Avoid indefinite terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59348

CERTIFICATE OF DEATH.

64 D 59348

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 328 Patapsco Ave ST. 26 St Helena WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Sully.

(Residence in Baltimore: No. 328 Patapsco Ave St Helena St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1867
(Month) (Day) (Year)

7-AGE, 54 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Coremaker
(b) General nature of industry, business, or establishment in which employed (or employer) ..... in Foundry

9-BIRTHPLACE, (State or Country), Tenn.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther Windsor

(Address) 328 Patapsco ave

15- Filed DEC 13 1921 191.. BUREAU OF STATISTICS Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 191.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Sydney Wilson M. D.
(Coroner.)

Dec 13, 1921 (Address) 1 East Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National Cem.	Dec. 14, 1921
20-UNDERTAKER	ADDRESS
Lilly + Zeiler	4038 Wolfe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 59349 HEALTH DEPARTMENT—CITY OF BALTIMORE 59349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willaim Copling

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST. Baltimore WARD Md.

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47 yrs	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Balto, Md.

15 Filed DEC 1 1921 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1920 to Dec 11, 19 21

that I last saw him alive on Dec 11, 19 21,

and that death occurred, on the date stated above, at 10'30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

Dec. 6, /21 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis chronic parenchymato
Endocarditis chronic (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ---

Was there an autopsy?

What test confirmed diagnosis? Clinic report

(Signed) Thomas B. Payne, M. D.
Senior Surgeon (R)

12/11, 1921 (Address) US. PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Dec 15 19 21

20 UNDERTAKER S. Levinson Bro

ADDRESS E. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 59350

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1542 N Washington ST.; 8 WARD)

2-FULL NAME James G Guy

(a) RESIDENCE. No. 1542 N Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 55 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should write

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James G Guy.

6 DATE OF BIRTH (month, day, and year) Oct 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Neumeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant James G Guy Jr (Address) 1542 N Washington

15 Filed DEC 13 1921 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15 . 1921 . to Dec. 11 . 1921.

that I last saw him alive on Dec 11 . 1921.

and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Frohn, M. D.

12/17 1921 (Address) 1823 N. Front St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dallstown

DATE OF BURIAL Dec 14 1921

20 UNDERTAKER Robt J Turner Inc

ADDRESS 1742 N Penn

D 59351 Rudzyska

HEALTH DEPARTMENT—CITY OF BALTIMORE

8 V D 59351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 306 Fagesta ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Rudzynska

(Residence in Baltimore: No. 306 Fagesta St. St.; 30 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Wid

6-DATE OF BIRTH, Dec 23, 1879.
(Month) (Day) (Year)

7-AGE, 42 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country) Poland

PARENTS.

10-NAME OF FATHER, John Rudzynska

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Josepha Kowalska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Josepha Kowalska
(Address) 224 Dean St

15-
Filed DEC 13 1921 191.... G C
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Coroner find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Henry Paul Neal Coy M. D.
(Coroner)
Dec 13, 1921 (Address) 1500 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	Dec. 14, 1921
20-UNDERTAKER M F Sadowski	ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 59352

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 S. Kenwood Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Kot

(a) RESIDENCE. No. 1101 S. Kenwood Ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~the Wife of~~ Mary Kot

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austrian-Poland

PARENTS

10 NAME OF FATHER Jacob Kot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austrian-Poland

12 MAIDEN NAME OF MOTHER Cecilia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austrian-Poland

14 Informant Anna Wisniewski
(Address) 1101 S Kenwood Ave

15 Filed DEC 13 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from November, 1921, to December 11, 1921, that I last saw him alive on Dec. 11, 1921, and that death occurred, on the date stated above, at 12:40 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

12-11, 1921 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	12-15-21
20 UNDERTAKER	ADDRESS
Stephan & Frackowiak	1000 Hanover

STATE REGISTRAR
Burial Permit Clerk

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59353 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59353

CERTIFICATE OF DEATH. 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Merchant, Miners Ave & ..... St., ... WARD) REGISTERED No. C

2-FULL NAME James Jones

(Residence in Baltimore: No. 725 Mulberry St.) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W	Married

6-DATE OF BIRTH, ... Unknown ....., 1857
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
64 yrs. ..... mos. ..... ds.	....hrs. or.....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 074

9-BIRTHPLACE, (State or Country). md.

PARENTS.

10-NAME OF FATHER, James Jones

11-BIRTHPLACE OF FATHER (State or Country). md

12-MAIDEN NAME OF MOTHER Sarah Whittington

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Ida Rawlings

(Address) 607 Gaza St

15-

DEC 13 1921 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apparent Chronic Nephritis
F. U from Shop

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. T. Kelly M. D.
(Coroner.)

Dec 12, 1921. (Address) 222 N

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 13 1921
20-UNDERTAKER John H. Toadvine	ADDRESS 147 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.59354

CERTIFICATE OF DEATH.

79 D 59354

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Carrollton Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Lewis

(a) RESIDENCE. No. 502 N. Carrollton ave. ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Lewis

6 DATE OF BIRTH (month, day, and year) Nov-12-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James R. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ann C. Hume

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Anne L. Burwell (Address) Annapolis Md

15 Filed DEC 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13-1921

17 I HEREBY CERTIFY, That I attended deceased from November 29, 1921, to December 13, 1921, that I last saw h im alive on December, 1921, and that death occurred, on the date stated above, at 8.55 a. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) — yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) organic heart disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Consultation + percussion

(Signed) Chester Riland, M. D.

12-13 1921 (Address) 2532 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchester Va	Dec. 13 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Fayette

BOYER & LEAUTE
Burial Permit Clerks

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59355

CERTIFICATE OF DEATH.

170 D 59355

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Fulton Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Annie E Poist.

(Residence in Baltimore: No. 702 Fulton Ave St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept (Month) 22 (Day), 1835 (Year)

7-AGE, 86 yrs. 2 mos. 20 ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Bernard Coyle

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Mary McKenzie.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. E. Parker

(Address) 702 W. Fulton Ave

15-

Filed DEC 13 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 12th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1921, to Dec 12 1921, that I saw her alive on Dec 11 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(Duration) 7 yrs. 6 mos. ds.

(Signed) George L. Shannon M. D.

Dec 12, 1921 (Address) 702 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Dec. 15, 1921

20-UNDERTAKER Joseph L Bork — ADDRESS 1003 N Balto St

N.B.—Every item of information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 59356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59356

104

1-PLACE OF DEATH Robert Garrett Hosp for Children REGISTERED NO.....

CITY OF BALTIMORE (No. 27 N. Carey ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Kellum

(a) RESIDENCE. NO. 114 E. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 1, 1920

7 AGE — Years: — Months: 11 — Days: 11 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm I Kellum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Alda S Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Wm I Kellum

(Address): 114 E Hamburg St

15 [illegible] DEC 13 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921, to Dec 12, 1921, that I last saw him alive on Dec 12, 1921, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. about 16 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. V. Clift, M. D.

12/12, 1921 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Dec 1921

20 UNDERTAKER: Jos'h B Cook — ADDRESS: 1013 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

(Sturm) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59357

CERTIFICATE OF DEATH.

D 59357

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Harper ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred H Sturm

(a) RESIDENCE. No. 1412 Harper Place ST. 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno.

6 DATE OF BIRTH (month, day, and year): Feb 2 1921

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jno

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas Sturm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ruth Chatterton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Chas Sturm

(Address) 1402 Harper Place

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 - 1921 to Dec 13 1921.

that I last saw h[illegible] alive on Dec 12 1921.

and that death occurred, on the date stated above, at 8 45 m.

The CAUSE OF DEATH* was as follows:

~~Stomach~~ Carcinoma of Liver

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) F H Wentz M. D.

12/23 1921 (Address) 1302 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 15 1921
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection foci

Spec.—8-24-14—M. & T.—2000 Bks.

D 59358

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59358

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Harford Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME John Klach

(Residence in Baltimore: No. 10 Harford Road ST.; Ham. Hts. Ward.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. 20, 1885
(Month) (Day) (Year)

7-AGE, 36 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Wood Carver
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Louis Klach

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary E Siebert

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis H. F. Klach

(Address) 10 Harford Hamilton

15-

Filed....., 191.....

Robert F. Harrison,

1 31921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 12 1921, to Dec. 12, 1921, that I saw h[illegible] alive on Dec. 12- 1921, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene L. Peroyne M. D.

Dec. 13, 1921 (Address) Ten Hills - Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, Dec. 15, 1921

20-UNDERTAKER William Cook ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

(Kolodnicki) ✓

D 59359 HEALTH DEPARTMENT—CITY OF BALTIMORE 1st D 59359

CERTIFICATE OF DEATH 25 - 7th ward

1-PLACE OF DEATH (717 Curtis Ave)

CITY OF BALTIMORE: (No. Curtis Bay, Baltimore ST. 7th Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kolodnicki

(a) RESIDENCE. NO. 717 Curtis Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-18-1918

7 AGE: Years 2 | Months 11 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Theodore Kolodnicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Josefa Nowak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Theodore Kolodnicki (Address)

15 [illegible] . 19 Registrar

DEC 13 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12-21 19

17 I HEREBY CERTIFY, That I attended deceased from 12-12-21 . 19 . to 12-12-21 19 .

that I last saw h~~im~~ alive on 12-12-21 . 19 .

and that death occurred, on the date stated above, at 330 P m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. B. Horton M. D.

. 19 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: Dec 14 19 21

20 UNDERTAKER: Jacob Fiallowski

ADDRESS: 425 S Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Minnie Priscilla) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59360

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1610 Bank St ST.; 3 WARD)

2-FULL NAME Minnie Priscilla

(a) RESIDENCE. NO. 1610 Bank St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Priscilla

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Angelo Priscilla (Address) 1610 Bank St

15 Filed Dec 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 10, 1921, that I last saw h[illegible] alive on " 10 1921, and that death occurred, on the date stated above, at A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Bright's Disease)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Warden, M. D.

Dec 13, 1921 (Address) 1610 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cem	Dec 15 1921

20 UNDERTAKER Wendell & Hupfeld ADDRESS 512 Lemmon

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to chronic valvular heart lesion

Spec.—1-10-21—M&T—1500 Blks.

D 59361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59361

87

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 6 WARD)

2-FULL NAME Rebecca Friedman

(a) RESIDENCE NO. 227 N. Wolfe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyman Friedman

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE: Years 68 years; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Abraham Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Frona

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Hyman Friedman 227 N. Wolfe St.

15 Filed DEC 14 1921

16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1921, to Dec 13, 1921, that I last saw her alive on Dec 13, 1921, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Zinberg, M. D.

12/2 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 12-14 1921

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 59362

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St. Ag Hospital St. 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Astroo

(Residence in Baltimore: No. 2216 Christian St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July 9 — , 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Irving Astroo

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Mary Polor

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I. Astroo

(Address) 1411 E. Balto.

15- BOWEN & CRAIGER

Filed DEC 14 1921 ADA Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns (Accidental)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)
Dec 13, 1921. (Address) 1423 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mount Wash Ld. DATE OF BURIAL, 12-14-, 1921

20-UNDERTAKER J. C. Lewis ADDRESS 1411 E. Balto. St

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59363

HEALTH DEPARTMENT—CITY OF BALTIMORE

81 ✓ D 59363

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 217 E. Biddle St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Smith

(a) RESIDENCE. NO. 217 E. Biddle St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick J. Smith

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	-----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Hugh McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Hugh McLaughlin

(Address) 217 E. Biddle St.

15 Filed DEC 14 1921 19 [illegible] Registrar

[illegible] Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1918 to Dec 13 1921

that I last saw her alive on Dec 12 1921

and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 3 + yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. -

(Signed) G. S. Theobald M. D.

Dec 14, 19 (Address) 1210 Gulford Ave.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 12/16 "19 21

20 UNDERTAKER Chas F. Evans & Son ADDRESS 1180 N. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 64 D 59364

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2126 Longwood St. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda C. Hart

(a) RESIDENCE NO. 2126 Longwood St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster, (State or country) Pa.

PARENTS

10 NAME OF FATHER Levi Hart

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ann Maria Krebs

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs. Lillian R. Coberth

(Address) 2126 Longwood St.

15 Filed DEC 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13th 19 21

17

I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1921, to Dec 13, 1921,

that I last saw her alive on Dec 13, 1921,

and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Not Known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 1/2 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. A. Schaefer, M. D.

, 19 (Address) 53 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Pa.	Dec 14 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59365

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1409 Mount St. 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Pierson

(a) RESIDENCE. No. 1409 N. mount St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Bertie Pierson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant B. Pierson
(Address) 1409 N Mount

15 Filed DEC 14 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9- 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 21- 1921, to 12-9 1921

that I last saw h.. alive on 12-9 1921

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Gastritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1409 n mount

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1617 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 14 1921
20 UNDERTAKER	ADDRESS
Edward Ringgold	1463 N Ave

Death in a Hospital

mation should be carefully supplied. Also that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59366

CERTIFICATE OF DEATH.

170 D 59366

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 515 N. Bruce ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth McClain

(Residence in Baltimore: No. 515 N. Bruce St.; yrs. 5 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem.	White	Widow

6-DATE OF BIRTH, March (Month), ... (Day), 1840 (Year)

7-AGE, 81 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo. Spalding

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jane Pellerman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Hopper

(Address) 3817 Chatam Road

15- Filed DEC 14 1921, 191.... MARY I. BAETJER Registrar.

Burial permit issued Forrest Park

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1921, to Dec 12 1921, that I saw her alive on Dec 9 1921, and that death occurred, on the date stated above, at 10.05 Pm.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) H. A. Hammond M. D.

Dec 14, 1921. (Address) 1919 Edmondson ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs 4 mos. ..... ds. In the State 21 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, St. Marys Irish. DATE OF BURIAL, Dec 15, 1921

20-UNDERTAKER H. C. Medefield ADDRESS 914 Fremont Ave

Spec.—8-24-14—M. & T.—1000 Bks.

D 59367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59367

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1125 Gorsuch ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sidney C Strutt

(Residence in Baltimore: No. 1125 Gorsuch ave St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	married

6-DATE OF BIRTH, July 19, 1848.
(Month) (Day) (Year)

7-AGE, 72 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Harford co md

PARENTS.

10-NAME OF FATHER, John I Wright

11-BIRTHPLACE OF FATHER (State or Country). Harford co md

12-MAIDEN NAME OF MOTHER Jane Morris

13-BIRTHPLACE OF MOTHER (State or Country). Harford co md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Strutt

(Address) 1125 Gorsuch ave

15-

Filed ....., 191.....

ROBERT J KRAUSER
Registrar.

DEC 14 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 6 1921, to December 13 1921, that I saw h. alive on December 13 1921, and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Had an attack of Uremia right Side Dec 6

abt

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Sudden (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) H Spann Wallbrook M. D.

Dec 13 1921 (Address) 1618 Gorsuch ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Wm Walters Cem Harford Co	Dec 16 1921

20-UNDERTAKER	ADDRESS
E G Kurtz & Son	Harrisville Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59368

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 7th. St.& 3rd. Ave Fairfields ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Johnson.(C)

(Residence in Baltimore: No. 7th. St.& 3rd. Ave. Fairfield. St.; yrs., 6 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE. 48 yrs. ? mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). A. A. Co. Md.

PARENTS.

10-NAME OF FATHER. James Johnson.(C)

11-BIRTHPLACE OF FATHER (State or Country). A. A. Co. Md.

12-MAIDEN NAME OF MOTHER. Rebecca Thompsom.(C)

13-BIRTHPLACE OF MOTHER (State or Country). A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William W. Johnson(C) husband.

(Address) 7. St. & 3rd. Ave. Fairfield.

15-

Filed DEC 14 1921 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12th. 1921. (Month) (Day) (Year) 191

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

Dec 12, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery DATE OF BURIAL, Dec 14, 1921

20-UNDERTAKER R. C. Gross ADDRESS 1405 McElderry

Spec.—6-9-19—H. P. Co.—1000 Bks.

59369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 S. Robinson ST.: 1 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Kane

(a) RESIDENCE NO. 307 S. Robinson ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of Samuel M. Kane

6 DATE OF BIRTH (month, day, and year) May 15 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Schwartzkopf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Emburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mr. Samuel M. Kane 307 S. Robinson St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1921

17 I HEREBY CERTIFY, That I attended deceased from 3rd Dec. 1921. to 12 Dec. 1921.

that I last saw h[illegible] alive on 12 Dec. 1921.

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic parenchymatous Nephritis (duration) ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

. 19 (Address) 3018 Elmwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 15 21

20 UNDERTAKER ADDRESS

Jos. J. Herr 151 N. Fremont.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 59370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59370

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD 9)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Peter Carey.

(a) RESIDENCE. NO. 625 Saint Paul Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secret Service

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Michael Carey.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Boyle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary Carey.
(Address) 625 St Paul Ave.

15 Filed DEC 14 1921 Burial Permit Issued

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5. 1921, to Dec 13, 1921, that I last saw him alive on Dec 13, 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Duodenum.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforation of Ulcer, Duodenum
Acute Nephritis (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 625 St. Paul St

Did an operation precede death? Yes Date of Dec 5. 1921

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Howard Mettauer, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	Dec 16 1921

20 UNDERTAKER E. A. Wiedefeld & Co. ADDRESS 501 E. 22 St

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation Dec. 5. 1921
Closing of perforated
Ulcer Hemostasis - and
Drainage of Abdominal Cavity.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59371

CERTIFICATE OF DEATH.

19 D 59371

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1414 Vincent alley ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Clark

(Residence in Baltimore: No. 1414 Vincent alley St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH. November, (Month) ..... (Day) 1887 (Year)

7-AGE. 34 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Laundress. (b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE. (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Anthony Downs

11-BIRTHPLACE OF FATHER (State or Country) Md.

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country) Don't Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Clark

(Address) 1414 Vincent alley.

15-DEC 14 1921 LOCAL REGISTRAR

Filed ....., 191.... Burial Permit Issued by Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophy of heart, chronic,

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. T. Hennessy M. D. (Coroner)

Dec. 13, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Druid Hill Cemetery.	Dec 15 1921
20-UNDERTAKER Louis H. Duvall	ADDRESS 1323 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59372

CERTIFICATE OF DEATH.

X 50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hospt. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret Jones.

(a) RESIDENCE NO Woodensburg, Baltimore Co, Md. ST.

(Usual place of abode) WARD.

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12, 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker. 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co, Md

PARENTS

10 NAME OF FATHER Chas W. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co, Md.

12 MAIDEN NAME OF MOTHER Ozella Linthicum.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co, Md.

14 Informant Mr. Millon Hunkle

(Address) Woodensburg Md

15 Filed DEC 14 1921 . 19

ROBERT F. FRANCKE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Dec 13, 1921,

that I last saw her alive on Dec 13, 1921,

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.
Chronic Interstitial Nephritis
Diabetic Gangrene.

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? yes Date of Dec 12, 1921

Was there an autopsy? no.

What test confirmed diagnosis? Urinalysis

(Signed) W. J. Coleman, M. D.

, 19 (Address) Md Gen. Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Gilard Cemetery	Dec 13 1921

20 UNDERTAKER Baltimore Md — ADDRESS

J. F. Elins — Reisterstown Md

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59373

CERTIFICATE OF DEATH

161

REGISTERED NO. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 20 Jos Hospital St.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Ann Price

(Residence in Baltimore: No. 242 S. Durham St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Widow

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7-AGE: 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: James Lumbery

11-BIRTHPLACE OF FATHER (State or Country): Cambridge Md

12-MAIDEN NAME OF MOTHER: Mary Wright

13-BIRTHPLACE OF MOTHER (State or Country): St Michaels Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore White

(Address) 113 W. Mt. St.

DEC 14 1921 Filed ....., 191.... Registrar

Social Service. Record

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns while lighting match (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Dudley M. D.
(Coroner)
12-13 1921 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem. DATE OF BURIAL: 12/15/21

20-UNDERTAKER: Sherdon White ADDRESS: 113 W Mt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59374

CERTIFICATE OF DEATH.

37-091

D 59374

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 14 WARD)

2-FULL NAME Emma Tucker Brown

(a) RESIDENCE. No. Unknown 1418 Argyle Ave ST., WARD.

(Usual place of abode) about 4 years (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Brown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) unknown.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Bay View Hospital Records.

15 DEC 14 1921 REGISTRAR Registrar

Registered Dec 14

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 11 1921

17

I HEREBY CERTIFY, That I attended deceased from November 27 1921, to December 11, 1921, that I last saw her alive on December 11, 1921, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Luetic Infection

unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? yes - Post Mortem findings -

What test confirmed diagnosis?

(Signed) H. McSmith M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sepulchre Va

DATE OF BURIAL 12/16/21

20 UNDERTAKER Felix B Pyle

ADDRESS 1022 Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Oracki)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59375 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59375

CERTIFICATE OF DEATH. 19-091.

1-PLACE OF DEATH Bay View Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Oriacki

(a) RESIDENCE. No. 2206 Bank ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Dec 10 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital records

15 Filed 19 Robert T. Matthews Registrar
C 14921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19. 1921. to December 12. 1921. that I last saw him alive on December 12. 1921. and that death occurred, on the date stated above, at 10:45 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) N. Goldsmith M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Dec 15 1921
20 UNDERTAKER	ADDRESS
John Gawlicki	1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59376

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1 Belvedere Ave. St. Charles Lakeland. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose A. Airey

(a) RESIDENCE No. Belvedere Ave & Charles St. Lakeland. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Airey

6 DATE OF BIRTH (month, day, and year) March 10th 1837.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	9	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Mulligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mary E. Blumenauer.
(Address) Belvedere Ave Charles St Lakeland.

15 Filed . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from July . 1921 . to Dec 12 . 1921.

that I last saw her alive on Dec 11 . 19 .

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hobbits Annie

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grundler, M. D.

12/13. 1921 (Address) 517 Leadenhall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec. 15th 1921
20 UNDERTAKER	ADDRESS
Mrs Mrs. John H. Teufel & Son	801 W. Fayette St.

141921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59377

D 59377

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4212 Penhurst Ave. ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide Gallagher

(a) RESIDENCE. No. 4212 Penhurst Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Wm J. Gallagher

6 DATE OF BIRTH (month, day, and year) July 18, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Tolle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Eberlein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Wm J. Gallagher
(Address) 4212 Penhurst Ave

15 Filed DEC 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1919 to Dec 13 1921, that I last saw h~~er~~ alive on Dec 13 1921, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about July 19

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Irvin Chaney M. D.

Dec 14 1921 (Address) 4212 Penhurst Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Dec 16 1921
20 UNDERTAKER	ADDRESS
Harry W. Ellen	W. North Ave

REASONS SHOULD BE STRICTLY OBSERVED. ALL should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59378

CERTIFICATE OF DEATH.

REGISTERED No. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 S. Clinton ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Selig Sr.

(a) RESIDENCE. No. 1701 S. Clinton ST., 76 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Selig

6 DATE OF BIRTH (month, day, and year) June 17-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Selig.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Anna F. Selig.
(Address) 1701 S. Clinton St.

15 Filed Dec. 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 31st, 1921, to December 12, 1921, that I last saw h[illegible] alive on December 11, 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 3 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. W. Fowler, M. D.

12/13 1921 (Address) 1013 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec. 15 1921
20 UNDERTAKER	ADDRESS
Lilly and Zeiler	403 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1 1921

Spec.—1-10-21—M&T—1500 Bks.

D 59379 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59379

CERTIFICATE OF DEATH. 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 E Fayette ST. 6 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelia Pope

(a) RESIDENCE NO. 1811 E Fayette ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mo. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27-21

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or min.
		4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip Pope

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Angelia Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Philip Pope (Address) 1811 E Fayette St.

15 Filed ..... 19..... Robert P. Harrison, Registrar

C 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 1921 to Dec 14 1921, 19..., that I last saw him alive on Dec 14 1921, 19..., and that death occurred, on the date stated above, at 1.25 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — (over)

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Accident Ill

Signed J. G. Calder, M. D.

(Address) 1437 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	12-15 1921
20 UNDERTAKER J. G. Moran	ADDRESS 300 E. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This child fell on her head—
Purely accidental.
Bladen MD

D 59380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59380

CERTIFICATE OF DEATH.

1464

REGISTERED No. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. Md. General Hosp. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Heiton

(Residence in Baltimore: No. 1531 Linden ave, St.; yrs., mos., ds.) 2

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH. November (Month) (Day), 1866 (Year)

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (General)

9-BIRTHPLACE, (State or Country). England

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Scofield

(Address) 934 N. Fulton ave.

15-

FILED DEC 15 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) J. J. Kenney M. D.
(Coroner)

Dec. 13, 1921 (Address) 2 So. Eutaw ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Harwood & Richmond Sts

Former or usual residence 1531 Linden ave

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec 15 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penna Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59381

CERTIFICATE OF DEATH.

D 59381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 9 W. Hamburg ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Chase

(a) RESIDENCE. No. 15 9 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 25th 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Annie Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge, Md.

14 Informant Harry Chase
(Address) 15 9 W. Hamburg st

15 Filed DEC 15 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1921, to Dec 14th, 1921, that I last saw him alive on Dec 13th, 1921, and that death occurred, on the date stated above, at 7.48 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. about mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. J. Hanvee, M. D.

12/14, 1921 (Address) 140 W. Lee st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 15 1921
20 UNDERTAKER A. Edward Bryan	ADDRESS 1631 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59382

CERTIFICATE OF DEATH.

170 D 59382

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1611 E. Pratt St. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Haggadorn

(a) RESIDENCE. No. 1611 E. Pratt St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Haggadorn

6 DATE OF BIRTH (month, day, and year) Apr. 8, 1843,

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 673

(b) General nature of industry, business, or establishment in which employed (or employer) Ticket Agent

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Staten Island N. Y.

PARENTS

10 NAME OF FATHER Francis L. Haggadorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Eliza Lawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Annie M. Warrington
(Address) 1611 E. Pratt St.

15 DEC 15 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1921, to Dec. 12, 1921, that I last saw him alive on Dec. 11, 1921, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Syncope

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Urinary Analysis

(Signed) W. J. Dilenbury, M. D.

19 (Address) 607 E. 27th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec. 15, 1921

20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59383

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Cedar St.& Curtis Ave. Curtis Bay WARD) 27

2-FULL NAME William Leander Foreman.

(Residence in Baltimore: No. 5843 York Road.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

51 St.; yrs., 8 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, April 7th. 1870., 1.....
(Month) (Day) (Year)

7-AGE, 51 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Secy. Curtis Bay
(b) General nature of industry, business, or establishment in which employed (or employer): Copper Co.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Leander Foreman.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Isabelle Ingram.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian P. Foreman. (wife)

(Address) 5843 York Road.

15-

Filed ..... 191.....

DEC 15 1921

ROBERT R. KRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) ....M. D.
(Coroner.)

Dec. 15., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetry

DATE OF BURIAL, Dec 15, 1921

20-UNDERTAKER Stewart & Company

ADDRESS 108 W. North Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59384

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64

D 59384

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 4008 Edmondson Ave ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Helen Robertson McCallister.

(Residence in Baltimore: No. 4008 Edmondson Ave St.; 3 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Nov 27, 1878 (Month) (Day) (Year)

7 AGE: 57 yrs. 0 mos. 20 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Chicago Ill

PARENTS

10 NAME OF FATHER: Wm McCallister

11 BIRTHPLACE OF FATHER (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Helen St Clair

13 BIRTHPLACE OF MOTHER (State or country): Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. McAllister (husband)

(Address) 4008 Edmondson Ave

15 DEC 15 1924

ROBERT R. KRAUTER, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 14 (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to Dec 14 1924, that I saw h.. alive on Dec 14, 1924, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

3 hrs

(Duration) yrs. mos. ds

Contributory (SECONDARY) Arteria Sclerosis & Chronic Nephritis (Duration) 2 yrs. mos. ds.

(Signed) Marshall B West M. D.

Dec 17, 1924 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death	—	—	—	In the State	—	—	—

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL: Philadelphia Penna

DATE OF BURIAL: Dec 16 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM J. MOWEN, Successor)

ADDRESS: 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59385

D 59385

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Homewood Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L Thomas Jr

(a) RESIDENCE. NO. Balto Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11-1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mr William L. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Bells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. W. L. Thomas (father)
(Address) Joppa Harford Co Md.

15 Filed DEC 13 1921 19 J. H. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1921, to Dec 14, 1921, that I last saw h-i alive on Dec 14, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Surgery Acute Peritonitis Perforated Stomach ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward C Morgan M. D

19 (Address) 1522 Henderson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cemetery Dec 15 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. If less than one day, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59386

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 616 n monroe ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Portia Darsey

(Residence in Baltimore: No. 616 n monroe St. (yrs. 0 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	col	Married

6-DATE OF BIRTH, ..., 1871
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), M. D.

PARENTS.

10-NAME OF FATHER, William Jones

11-BIRTHPLACE OF FATHER (State or Country), M. D.

12-MAIDEN NAME OF MOTHER, Mary Harris

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Jones

(Address) 183 white st

15- DEC 15 1921 ROBERT R. KRAUTER,
Filed....., 191.... Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner)
12-15 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, Dec 16, 1921

20-UNDERTAKER Chas C. Bailey — ADDRESS 1431 Jefferson st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 59387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1170 D 59387

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1614 Edmondson Ave ST., 16 WARD)

2-FULL NAME Taylor Zacariah Simmons

(a) RESIDENCE No 1614 Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Simmons

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 67 Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Taylor J. Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Taylor Simmons

(Address) 1614 Edmondson Ave

15 Filed DEC 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1921, to Dec 14, 1921, that I last saw him alive on Dec 14 1921 and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? The usual

(Signed) Virt A. Bryan M. D.

, 19 (Address) 3523 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Dec 1921

20 UNDERTAKER: H. Hubbard Sons

ADDRESS: Roma

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59388

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1254 N. Gay ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Taylor

(a) RESIDENCE. No. 1254 N. Gay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced (or) WIFE of Walter B Taylor

6 DATE OF BIRTH (month, day, and year) Sept 24 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Wm Wearer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Lucy Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Walter B Taylor (Address) 1254 N Gay St

15 Filed DEC 15 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1921, to Dec 12, 1921, that I last saw h alive on Dec 12, 1921, and that death occurred, on the date stated above, at 10.05 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Acute Pharyngitis

(duration) yrs 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney A. Hugot M. D.

(Address) 4605 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 15 1921
20 UNDERTAKER	ADDRESS
Robt J Turner	1142 W Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of Heart Disease

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59389

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Hoffman

(a) RESIDENCE. NO. 18, South Chester ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White Russian Jew

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Mr. Louis Hoffman

6 DATE OF BIRTH (month, day, and year): August 1 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia.

PARENTS

10 NAME OF FATHER: Abraham Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Gran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia,

14 Informant: Hospital Records (Address): U. P. J.

15 Filed DEC 15 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 15 1921

17 I HEREBY CERTIFY, That I attended deceased from December 1, 1921, to December 15, 1921, that I last saw her alive on December 15, 1921, and that death occurred, on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 9, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. S. L. Hoffman, M. D.

, 19 (Address) 1512 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom Cem	12-15 1921

20 UNDERTAKER: Jack Krantz ADDRESS: 1411 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for
Exophthalmic
goitre

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59390

CERTIFICATE OF DEATH.

33 D 59390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Broadway ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Sweeney

(a) RESIDENCE NO. 822 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Sweeney

6 DATE OF BIRTH (month, day, and year): Aug 26 1860

7 AGE: Years 58 Months 3 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Patrick Murry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Feehly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs. Sweeney.

(Address): 822 N. Broadway.

15 Filed DEC 15 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1909, to Dec 13, 1921, that I last saw h[illegible] alive on " 12, 1921 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

General Joint Glandular Tuberculosis

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) T. J. Feehly, M. D.

12/14 1921 (Address) 110 E North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 12/16 1921

20 UNDERTAKER: John C. Moran — ADDRESS: 3000 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 59391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 59391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1041 N. Milton ave ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael A. Flynn

(a) RESIDENCE NO. 1041 N. Milton ave ST., 6 WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Flynn

6 DATE OF BIRTH (month, day, and year) Feb 26 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Tob

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Michael Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire

12 MAIDEN NAME OF MOTHER Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Mrs Phelen (Address) 1041 N. Milton ave

15 Filed DEC 15 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 19 21, to Dec 13, 19 21,

that I last saw h alive on Dec 13, 19 21

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interst. Nephritis (duration) Hemiplegia yrs. 9 mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. D. Meyer Jr. M. D.

12/15 19 21 (Address) 1638 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 12/16 1921

20 UNDERTAKER John A Moran — ADDRESS 3000 E Balto.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167

D 59392

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1714 Lancaster ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Kasmira Zalenska

(Residence in Baltimore: No. 1714 Lancaster St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, June 14, (Month) 12 (Day) 1920 (Year)

7-AGE, 1 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. (child)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wladyslaw Kalinski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Antonia Bobye

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wladyslaw Kalinski

(Address) 1714 Lancaster St.

15- Filed DEC 15 1921, 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns (flame) accidental

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Shock,

(Duration) yrs. mos. 1 ds.

(Signed) G. Lee Blades M. D.
(Coroner.)

Dec 14 191.. (Address) 1436 Piney

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem	Dec 16, 19..

20-UNDERTAKER Jacob Tall & Sons ADDRESS 1884 E. Baltimore St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

[illegible] Sister Shelle Burns Her Child accidentally, Was attended by Dr. J. H. Pettegrew,

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Lillian H Green) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59393

CERTIFICATE OF DEATH.

136 D 59393

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.:) 27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Melvin Green

(a) RESIDENCE. No. 74 Roland Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of J Melvin Green

6 DATE OF BIRTH (month, day, and year) Apr 24 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Harrison

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Anna Wilson

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mercy Hospital Balt
(Address)

15 Filed DEC 15 1921, 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13-1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1921, to Dec 13, 1921, that I last saw h.. alive on Dec 13, 1921, and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia
Nephritis

(duration) 6 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) .... yrs. 2 mos. .... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of Dec 10, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 15th 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins Sons Co	Orchard Mc Collough St

INFORMATION should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis.
Cesarean section.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Shauck.

D 59394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59394

91

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 E. Lanvale St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Posina Shauck

(a) RESIDENCE. NO. 212 E. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 7-1845

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Peter D. Shauck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Wise
(Address) 212 E Lanvale St

15 DEC 15 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Dec 13, 1921, that I last saw h[illegible] alive on Dec 13, 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph D. Herring, M. D.

19 (Address) Waldorf 1818 N. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Dec. 16 19

20 UNDERTAKER William J. Foy — ADDRESS 1753 W. Fay-ette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59395 D 59395

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1809 E 29 ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John O'Neill

(Residence in Baltimore: No. 837 E Chase St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, 12 (Month) 13 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos....ds.	....hrs. or 7 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, David O'Neill

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Whitty

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David O'Neill

(Address) 837 E. Chase St.

15-

Filed [illegible], 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/13 1921, to 12/13 1921, that I saw h[illegible] alive on 12/13 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho - [illegible]

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.

12-14, 1921. (Address) 917 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cem	Dec 16, 1921

20-UNDERTAKER	ADDRESS
F. A. Kranse & Son	703 Hanover

15 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

TARVER

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59396

CERTIFICATE OF DEATH.

X 43 D 59396

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 W. Lanvale St. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Essex Ave

2-FULL NAME Maggie J. Tarver

(a) RESIDENCE NO. 311 W. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14" 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jasper
(State or country) Tenn.

PARENTS

10 NAME OF FATHER A. M. Stone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Francis B. Swafford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Tenn.

14 Informant Miss Aline Sexton
(Address) 311 W. Lanvale St.

15 Filed , 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14" 19 21

17 I HEREBY CERTIFY, That I attended deceased from July , 1921 , to Dec 14 1921 , 1921 ,
that I last saw her alive on Dec 14 1921 , 1921 ,
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Epithelioma of right breast

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D. Lightcap, M. D.
19 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dom. Gorgas	Dec 16" 19 21
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Calvert St

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 S. Kenwood Ave. St.) 1 (WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hundt.

(a) RESIDENCE. No. 804 S. Kenwood Ave 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Bernard H. Hundt.

6 DATE OF BIRTH (month, day, and year) Dec 9th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Bahlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katharine Henderson
(Address) 804 S. Kenwood ave

15 Robert P. Harrison, Registrar
Burial Permit Clerk

DEC 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1921, to Dec 14, 1921, that I last saw her alive on Dec 13, 1921, and that death occurred, on the date stated above, at 9 45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy
arteriosclerosis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. J. McAvoy, M. D.

Dec 15 1921 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 17 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

d be stated EXACTLY. PHYSICIANS should make y be properly classified. Exact statement of OCCUPA- k of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59398

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 59398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 Druid Hill Ave St. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice A Taylor

(Residence in Baltimore: No. 2233 Druid Hill Ave St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Color

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 16, 1846 (Month) (Day) (Year)

7-AGE, 55 yrs. mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), New York.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lee Dayton

(Address) 2233 Druid Hill Ave

15-

Filed ....., 191....

Robert P. Garrison, Registrar.

Burial Permit Clerk.

15 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13, 1921. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 28 1920, to Dec 13th 1921, that I saw h[er] alive on Dec 13th 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 4 ds.

(Signed) D. P. Boisaubin M. D.

, 191... (Address) 3716 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Dec. 16., 1921

20-UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Duplicate

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59399 ~~D 59399~~ 89 D 59399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1821 Lemmon St. 19 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Hobritter

(Residence in Baltimore: No. 1821 Lemmon St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): SINGLE

6-DATE OF BIRTH, July 26th, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, George Hobritter

11-BIRTHPLACE OF FATHER (State or Country). MD

12-MAIDEN NAME OF MOTHER Kate Yockel

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Hobritter

(Address) 1831 Lemmon St

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

DEC 15 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Capt. Bronchitis

8

(Duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) 1 hrs. mos. ds.

(Signed) W. C. Bates M. D.
(Coroner)

Dec 14 1921 (Address) 1736 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Ot. Peters Cem — DATE OF BURIAL, Dec. 16, 1921

20-UNDERTAKER A Jones — ADDRESS 2078 Hudson

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1821 Lemon St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Holcritter

(Residence in Baltimore: No. 1821 Lemon St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 13 ....., 1911
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Bronchitis

(Duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 6 mos. 1 ds.

(Signed) Geo Edmond Blades M. D.
(Coroner.)

Dec 14, 1911 (Address) 143 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59400

D 59400

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Julia E. Hartley

(a) RESIDENCE. No. 3130 Dillon ST.. WARD. St. Mary's # 20
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Hartley

6 DATE OF BIRTH (month, day, and year) Apr. 12th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Inekling

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Rose Eberle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Harry Hartley

(Address) 3130 Dillon St

15 [illegible] . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 19 21. to Dec. 14, 19 21.

that I last saw him alive on Dec. 14, 19 21.

and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman J. Dorf, M. D.

. 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patrick's Cem	12 17 1921
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59401 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59401

CERTIFICATE OF DEATH.

REGISTERED NO. C 47

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 900 S. Carey ST. 6 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME John H. Heuer

(Residence in Baltimore: No. 125 N. Patterson Pk Ave St. 11 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Aug 29, 1860 (Month) (Day) (Year)

7-AGE, 61 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coach Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Car Shops

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Frederick Heuer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henriette Berger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Heuer

(Address) 125 N. Patterson Pk Ave

15- Robert P. Harrison,

Filed DEC 13 1971, 191.... Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1971 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquiry and Post Mortem, and from autopsy, inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
Bronchopneumonia
(Duration) 2 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Bronchiectasis
(Duration) yrs. mos. ds.

(Signed) H. G. Hodges M. D.
(Coroner)
Dec 14 1971 (Address) 1437 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Dec 16, 1971

20-UNDERTAKER Wm C. Miller

ADDRESS 2334 Jefferson St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59402

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Duncan ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Yanmer.

(a) RESIDENCE. No. 633 Duncan ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Yanmer

6 DATE OF BIRTH (month, day, and year): April 23-1872

7 AGE: Years 49 | Months 8 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George Long

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Joseph Yanmer 633 Duncan

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 14 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 14 1921, that I last saw her alive on Dec 14 1921, and that death occurred, on the date stated above, at 6 p- m.

The CAUSE OF DEATH* was as follows:

Valvular Dis - of heart

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Gen Conversion of Lung — 3

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Undersigned M. D.

, 19 (Address) 125 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mathews Cemetery — DATE OF BURIAL: Dec 18 1921

20 UNDERTAKER: Wm Co Miller — ADDRESS: 233 Dolphin St

DEC 13 1921

Burial Permit Clerk.

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59403

43 D 59403

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Laycock

(a) RESIDENCE. No. 3504 Old Frederick Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS.

10 NAME OF FATHER John Carr

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary McCormick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Hospital Records.
(Address) Municipal Hospital.

15 DEC 15 1921 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 19 21

17 I HEREBY CERTIFY, That I attended deceased from October 22, 1921, to December 15, 1921, that I last saw her alive on December 15, 1921, and that death occurred, on the date stated above, at 1:30 A.M. The CAUSE OF DEATH* was as follows:

Carcinoma of the Breast

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Carcinoma

(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. E. Goodrich, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sinai Hebrew Cemetery	Dec 19 1921
20 UNDERTAKER	ADDRESS
Jno. C. Smith	2334 Reisterstown Rd.

Robert P. Harriet,
Burial Permit Clerk.

REPORT SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59404

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59404

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2337 McElderry ST. 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F Stout

(a) RESIDENCE NO. 2337 McElderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed or Divorced (write the word)~~

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Martha Stout

6 DATE OF BIRTH (month, day, and year) Oct 12 1865

7 AGE: 56 Years | 2 Months | 1 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Gas co

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Martin Stout

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Martha Stout 2337 McElderry st

15 Filed DEC 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1907, to Dec 12, 1921, that I last saw h[illegible] alive on [illegible], 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Colenberg M. D.

Dec 14 1921 (Address) 1810 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 16 1921
20 UNDERTAKER	ADDRESS
Thos. C. Miller	233 N. Gay St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. Each item should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59405 · 10 5 5 / D 59405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 Columbia Ave ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Farrell

(a) RESIDENCE NO. 848 Columbia Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Farrell

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gas. Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Gas Co

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Farrell

(Address) 848 Columbia ave

15 Filed DEC 16 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 12, 1921, that I last saw him alive on Dec 10, 1921, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Hypo Static Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) J Wesley Young, M. D.

Dec 13 1921 (Address) 72 Holcomb Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 16 1921

20 UNDERTAKER Leonard Sons & Hamburg ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59406

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Ostend St. & Peach Alley ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Thomas.

(Residence in Baltimore: No. 182 W. Cross St.

52 ------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, November 4th. 1862. (Month) / (Day) / (Year)

7-AGE, 59 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wood worker.
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, William Thomas.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Sarah Christopher

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Thomas. (wife)

(Address) 182 W. Cross St.

15- Filed DEC 16 1921 191 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13th. 1921. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Prokop M. D. (Coroner.)

Dec. 15, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	Dec 16 1921
20-UNDERTAKER	ADDRESS
Margaret G. Flynn	14 W. Lexington St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59407

CERTIFICATE OF DEATH.

170 D 59407

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Burck

(a) RESIDENCE. NO. 531 S. Belnord Ave. WARD. St. Anns

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23d 1847

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	74	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Mass.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Nats

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germay

14 Informant Frank L. Mass.
(Address) 531 S. Belnord Ave.

15 DEC 16 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to Dec 15, 1921, that I last saw h m alive on Dec. 15, 1921, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman F. Dorf, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec 17 1921
20 UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 59408

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 210 S. 8th St. ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelo Consolare

(Residence in Baltimore: No. 210 S 8th St. St. 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct 16th, 1881
(Month) (Day) (Year)

7-AGE, 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Raffale Consolare

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Carmela Consolare

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Maggetta

(Address) 210 S. 8th St.

15- Filed DEC 16 1921, 191... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon und from the evidence obtained by said (Inquest, autopsy or inquiry.) Medicine find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a)
Labor Pneumonia
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thomas Wm Kinsley M. D.
(Coroner)
Dec 16, 1921 (Address) Booth Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cemetery. DATE OF BURIAL, Dec 16, 1921

20-UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Infant - Prostak

D 59409

Spec. 6-9-19—B. R. Co.—1000 Bks.

D 59409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N Eden ST. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Child Prostak

(a) RESIDENCE. No. 229 N Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 5/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Hyman Prostak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Eva Fastman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Prostak
(Address) 229 N Eden St

15 DEC 16 1921

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Dec 16, 1921, that I last saw him alive on Dec 16, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Eph. M. D.

, 19 (Address) 1904 E. Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bethel Rd Southern ave	Dec 1921
20 UNDERTAKER Max Levinson	ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59410

CERTIFICATE OF DEATH.

X 30

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Childrens Hospital School ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reginald Gibson

(Residence in Baltimore: No. Childrens Hospital School St.: ..... yrs., 1 mos. 14 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female.	White	Single.

6-DATE OF BIRTH, November (Month) 4th (Day), 1918 (Year).

7-AGE, 3 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None. 000

9-BIRTHPLACE, (State or Country), Charleston W Va.

PARENTS.

10-NAME OF FATHER, Earl M Gibson

11-BIRTHPLACE OF FATHER (State or Country), Strange Creek W Va.

12-MAIDEN NAME OF MOTHER Bertha E. Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Strange Creek W Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H E Bennett

(Address) 4 E Madison St

15- DEC 16 1921 Filed ..... 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1921, to Dec 14 1921, that I saw him alive on Dec 13- 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. 9 mos. ..... ds.

(Signed) H. E. Bennett M. D.

Dec 14, 1921. (Address) 4 E Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 14 ds. In the State ..... yrs. 1 mos. 14 ds.

Where was disease contracted, if not at place of death? Charleston W Va

Former or usual residence Charleston W Va.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Strange Creek, Braxton Co W Va	Dec 16 1921

20-UNDERTAKER W. Benjamin Gore

ADDRESS 1723 W Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks.

Zepp ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59411

CERTIFICATE OF DEATH.

79 D 59411

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 S. Stricker St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Estella Zepp

(a) RESIDENCE NO. 304 S. Stricker St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Albert Zepp

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Magdalena Calloway

13 BIRTHPLACE OF MOTHER (city or town) Mansfield
(State or country) Ohio

14 Informant Thomas H. Zepp
(Address) 304 S. Stricker St.

15 Filed DEC 16 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14th 19 21

17

I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1921, to Dec 14, 1921,

that I last saw her alive on Dec 13, 1921,

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) Edw. V Coolahan, M. D.

Dec. 21, 19 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Dec. 16, 1921
20 UNDERTAKER Joseph L. B Cook	ADDRESS 1003 N Paca St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Isadore E. Belz

D 59412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59412

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maple Ave. Franklintown Md ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isadore E. Belz

(a) RESIDENCE NO. Maple Ave. Franklintown Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Belz

6 DATE OF BIRTH (month, day, and year) Sept. 7th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Poultry 045

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer for self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Casper Belz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eve ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Sarah Belz
(Address) Maple Ave. Franklintown, Md.

15 Filed DEC 16 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1921, to Dec 14, 1921,

that I last saw h in alive on Dec 14, 1921,

and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) W. S. Tibbett, M. D.

19 (Address) 2220 Harrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 17 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Calvert St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59413 — 59413 — 59413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St.) 23 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ranscher

(a) RESIDENCE. No. 15 W. Cross St. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Ranscher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Virginia Brocato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Record

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1921, to Dec 15th, 1921, that I last saw her alive on Dec 15th, 1921, and that death occurred, on the date stated above, at 2 15 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery) and Bronchio Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Nonie F. Stewart, M. D.

12/16 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. (Brooklyn)	Dec 16 192
20 UNDERTAKER	ADDRESS
J Herwig & Co	2008 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU TION is very important. See instructions on back of certificates.

D 59414

(Sinn)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59414

159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20 W Preston St.; 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert A. Sinn

(Residence in Baltimore: No. 20 W. Preston St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 65 about yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Coal Runner
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Balto -

PARENTS.

10-NAME OF FATHER, Robt. Sinn

11-BIRTHPLACE OF FATHER (State or Country) Scotland

12-MAIDEN NAME OF MOTHER Martha Thompson

13-BIRTHPLACE OF MOTHER (State or Country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. V. Sinn

(Address) Wash. Co

15-

Filed ....., 191.... Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gunshot shot
wound in brain.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. J. Riley M. D.
(Coroner.)

Dec 15, 1912 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Dec. 16, 1912

20-UNDERTAKER ADDRESS

E. J. Finnerty & Son 1938 Lafayette Ave

Form —6-9-19—H. P. Co.—1000 Blks.

D 59415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 59415

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 S. Sharp ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Briscoe

(a) RESIDENCE. No. 810 Sharp ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col,	Widow

5a If married, widowed, or divorced (or) WIFE of Peter Briscoe

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 60	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Co. Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Peggy Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Co. Va

14 Informant (Address) Mason Briscoe 810 Sharp St.

15 Filed DEC 1, 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4th, 1924, to Dec 14, 1924, that I last saw her alive on Dec 13th, 1924, and that death occurred, on the date stated above, at 4 A.M. The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart (mitral insuffiency

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Renal Insufficiency

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Campbell, M. D.

12/1.3/1924 (Address) 1400 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 16 1924
20 UNDERTAKER John H. Trader	ADDRESS 142 Mitchell St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Millman)

D 59416 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 15 D 59416

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 400 N. Fremont St.: 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Millman

(a) RESIDENCE No. 400 N. Fremont St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 400 N. Fremont

PARENTS

10 NAME OF FATHER Charles Millman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Edith Hyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Edith Millman
(Address) 400 N Fremont

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1921, to Dec. 16, 1921, that I last saw him alive on Dec. 16, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Compression during birth.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchner, M. D.

... 19 (Address) 650 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Hebrew Washington Rd Dec 16 1921

20 UNDERTAKER — ADDRESS

Max Lennon Balto

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Otter

59417

CERTIFICATE OF DEATH.

64 D 59417

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 China ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Otter

(Residence in Baltimore: No. 613 China St.; ....yrs.,.... mos.... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1884
(Month) (Day) (Year)

7-AGE, 37 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Job Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Otter.

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co Md.

12-MAIDEN NAME OF MOTHER Mary Stanley

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver Otter

(Address) 613 China St.

15- Filed DEC 16 1921, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13th 1921, to Dec 14 1921, that I saw him alive on Dec 14 1921, and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the Brain

(Duration) ....yrs., 48 hrs mos. ....ds.

CONTRIBUTORY (Secondary) General Paralysis

(Duration) ....yrs. ....mos. 4 hrs ds.

(Signed) C. L. MacKall M. D.

Dec 15, 1921. (Address) 130 S. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Dec ....., 191...

20-UNDERTAKER David Carlin

ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59418

CERTIFICATE OF DEATH.

167

D 59418

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie May ~~Jones~~ Shipley

(Residence in Baltimore: No. 1132 Shields Al St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 6 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Lewis H Shipley

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Rose Bolon

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Shipley

(Address) 1132 Shields Alley

15-

Filed DEC 16 1921, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns 1 & 2 degree
(placing papers in stove)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) H T Ruby M. D.
(Coroner)

Dec 16, 1921 (Address) 1159 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Dec 16, 1921

20-UNDERTAKER David Caplan

ADDRESS 916 Pa ave

D 59419 HEALTH DEPARTMENT—CITY OF BALTIMORE

156 D 59419

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1826 E. Pratt St., ST. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Katzoff

(Residence in Baltimore: No. 1826 East Pratt St. 10 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1899 (Year)

7-AGE, 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jacob Katzoff

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ida Etta ------

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balto. St.

15-

Filed DEC 16 1921, 191.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

12-16-, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Woodlawn Circle Int. Carmack	12-18-21

20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59420 Smith

CERTIFICATE OF DEATH.

D 59420

39

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Homestead St ST.: 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Smith

(Residence in Baltimore: No. 1412 Homestead St.; St.: 9 yrs., 11 mos. 29 ds.)

9

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, December 16, 1841
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
79 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0.0.

9-BIRTHPLACE, (State or Country), City Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Hecht

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary A Whitely

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred H. Taft

(Address) 1412 Homestead St

15- DEC 16 1921 ROBERT R. KRAUTER Burial Permit Clerk

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 1920 191, to Dec 15 1921 191,

that I saw her alive on Dec 15 1921 191,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Jaw (Lower)

(Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(Duration) 2 yrs. mos. ds.

(Signed) Jno L Heberling M. D.

Dec 16, 1921 (Address) 2042 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence Haverford Pa

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge | DATE OF BURIAL, Dec 17, 1921

20-UNDERTAKER John Ouitchek | ADDRESS 120 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59421

CERTIFICATE OF DEATH.

40 D 59421

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3612 Sycamore ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Wasserheimer

(a) RESIDENCE. NO. 3612 Sycamore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 25-1861

7 AGE — Years: 60 Months: 5 Days: 20 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of Industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Maryland.

PARENTS

10 NAME OF FATHER: Peter Wasserheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan Sterner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Elza Ehrett (Address) 3612 Sycamore St.

15 Filed DEC 16 1921 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1921, to Dec 15, 1921, that I last saw her alive on Dec 15, 1921, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. Wurth M. D. M. D.

12/16 1921 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet - Hanover, Pa. DATE OF BURIAL: Dec. 18 1921

UNDERTAKER: Horace H. Burgee ADDRESS: 363 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59422

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 N. Patterson Pk Ave ST.: 8 WARD)

2-FULL NAME Mollie G. Rosenwirth

(a) RESIDENCE. No. 1909 N Patterson Pk Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Rosenwirth

6 DATE OF BIRTH (month, day, and year) 1/31/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. J. Rudloff

(Address) 1909 N Patterson Park Ave

15 Filed 19 Robert P. Harrison, Registrar

C 1 61921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1921, to Dec 15th, 1921, that I last saw h[illegible] alive on Dec 10th, 1921, and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma,
Tumor of Pelvis,
Chronic Endocarditis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Senile Debility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Court C. Ellis M. D.

Dec 16 1921 (Address) 938 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	12/19 1921
20 UNDERTAKER Albert L Hiltz, Jr.	ADDRESS 1606 N Chester St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59423

CERTIFICATE OF DEATH.

120 D 59423

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 609 N. Bethel (St.) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Lewis

(a) RESIDENCE. No. 609 N. Bethel St.. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	married

5a If married, widowed, or divorced (or) WIFE of James Lewis

6 DATE OF BIRTH (month, day, and year) Most day unknown yr. 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anarundel Co Md.

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anarundel Co Md.

12 MAIDEN NAME OF MOTHER Dorie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anarundel Co Md.

14 Informant (Address) James Lewis (Husband) 609 N Bethell

15 Filed ....., 19.... Robert P. Harrison Registrar

DEC 16 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14 1921

17

I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to Dec. 14, 1921, that I last saw her alive on Dec. 14, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) 6 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Nephritis Parenchymatous

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab Exams

(Signed) R. J. Young M. D.

, 19 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Dec 16 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 515 N. Bethel St (ST.,) 7 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dottie Holiday

(a) RESIDENCE NO. 515 Bethel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Holliday unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
21	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 070

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore Ball-City

PARENTS

10 NAME OF FATHER Johnie Hamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elnora Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Her Grandmother Julia Johnson
(Address)

15 Dec 17 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

C 161921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14, 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10- 1921 to Dec. 14, 1921.

that I last saw her alive on December 14, 1921

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

apoplexy & Broncho Pneumonia

OVER

..... (duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. L. W. Kennard, M. D.

12-19-1921 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millington Md	Dec 17. 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Luetic.

Spec.—5-19-13—M. & T.—500 Blks.

D 59425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59425

CERTIFICATE OF DEATH.

61

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Magnolia Graniun Ave ST.; 25 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Wambach

(Residence in Baltimore: Magnolia and Graniun) Enghish Consul St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mch 25, 1 (Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bleak
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country) Balto md

PARENTS.

10-NAME OF FATHER, Geo W Wambach

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Sophia Gorly

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Verona Wambach

(Address) English Consul

15- Robert P. Harrison,

Filed ..... 191.....

C 161921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1921, to Dec 15 1921, that I saw him alive on Dec 15 1921, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Septic Meningitis Acute:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Infection of Right Frontal and Right Sphenoid Sinus

(Duration) 15 yrs. mos. ds.

(Signed) Edwin Sachs Rennert M. D.

Dec 16, 1921 (Address) 812 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Dec 17, 1921

20-UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 59426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59426

CERTIFICATE OF DEATH.

79-54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4713 Homer Ave ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Brinsfield Morris

(a) RESIDENCE NO. 4713 Homer Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Elwood Morris

6 DATE OF BIRTH (month, day, and year) July 2, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co., Md.

PARENTS

10 NAME OF FATHER Peter Brinsfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co. Md.

12 MAIDEN NAME OF MOTHER Susan Matilda Medders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Augusta B. Pellman (Address) Annapolis, Md.

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk

DEC 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/15 1921

17

I HEREBY CERTIFY, That I attended deceased from 11/30, 1921, to 12/15, 1921, that I last saw her alive on 12/15, 1921, and that death occurred, on the date stated above, at 1.00 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary (Bronchial)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Medical Regulation, Nephritis, Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptomatology

(Signed) Henry Russell, M. D.

, 19 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Kent Co Md.

DATE OF BURIAL DEC 17 1921

20 UNDERTAKER Wm J Hartwell

ADDRESS 2236 W. Baltimore

56

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59427

CERTIFICATE OF DEATH.

D 59427

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 2570 Greenmount ave. ST.) 12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Simms

(a) RESIDENCE. (Usual place of abode) No. Mt. Vernon, Md. ST., WARD Mt. Vernon Md.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
62 1859	Dec	28th	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Mt. Vernon Maryland

PARENTS

10 NAME OF FATHER Gray

11 BIRTHPLACE OF FATHER (city or town) Rockville Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER not known 12/16

13 BIRTHPLACE OF MOTHER (city or town) Rockville Co. (State or country) Maryland

14 Informant W. H. Simms (Address) 2129 W. North ave

15 Filed ____, 19 ____ Registrar

Burial Permit Clerk.

C 16192

Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Dec 16, 1921, that I last saw her alive on Dec 16, 1921, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cerv)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? yes Date of ~~Nov~~ Oct 31/21

Was there an autopsy? None

What test confirmed diagnosis? Operation

(Signed) E. Miles Wheeler, M. D.

(Address) 2129 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, ~~CREMATION~~ OR REMOVAL	DATE OF BURIAL
Mt Vernon Md	12/17 19
20 UNDERTAKER William Cook	ADDRESS 502 E North

R

Should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Carcinoma of the Uterus.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59428

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Patapsco ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Theresa Mortimer

(a) RESIDENCE. NO. 1606 Patapsco ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert J. Mortimer

6 DATE OF BIRTH (month, day, and year): Dec 1891

7 AGE: Years 30; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): House-work

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Brooklyn Md

PARENTS

10 NAME OF FATHER: Gustav Ruchel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles F. Ruchel
(Address): 1717 S. Charles St

15 Filed: Robert P. Harrison, Registrar

DEC 16 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1921, to Dec 15, 1921, that I last saw h[illegible] alive on Dec 15, 1921, and that death occurred, on the date stated above, at 4.25 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell, M. D.

Dec 16, 1921 (Address) 1624 Johnson Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A & Co	Dec 17 1921
20 UNDERTAKER	ADDRESS
John F. Denny	715 Eighth

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59429

CERTIFICATE OF DEATH.

15 / D 59429

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE) No. 1606 Patapsco St., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs J. A. Mortimer

(a) RESIDENCE. No. 1606 Patapsco St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) Dec 14/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John A Mortimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie J. Reichel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John A Mortimer
(Address) 1606 Patapsco St.

15 Filed ... 19... Robert P. Lamdin, Registrar

DEC 16 1921

Asst. Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Dec 15, 1921, that I last saw h alive on Dec 14, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

5 Mos. uterogestation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr. Emmanuel

Signed H. K. Campbell M. D.

Dec 15, 1921 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A & Co	Dec 17 1921
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59430

CERTIFICATE OF DEATH.

D 59430

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Smith

(a) RESIDENCE. No. 653 George St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chestertown Maryland

12 MAIDEN NAME OF MOTHER Amanda Joney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1921

17

I HEREBY CERTIFY, That I attended deceased from December 13 1921, to December 14 1921, that I last saw her alive on December 14, 1921, and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Cardyconnata of Cholera

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Operation Shock

(duration) 1/2 hours dy.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 14 1921

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) L. W. Broadus, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. W. Woburn Son	Dec 15 1921
20 UNDERTAKER	ADDRESS 916
David Easton	Pa ave

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1060 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59431 ✓ 37 D 59431

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Baybrin Hospital

CITY OF BALTIMORE: (No. ..... ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Deal

(a) RESIDENCE. NO. 1222 Bayard ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Auburn

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Baybrin Hosp. (Address) Balto, Md.

15 Filed ..... Robert P. Harrison, Registrar

DEC 17 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1921, to Dec. 15, 1921, that I last saw him alive on Dec 15 1921 and that death occurred, on the date stated above, at 4.35 P.M.

The CAUSE OF DEATH* was as follows:

General Paralysis (Luetic Origin)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Serological

(Signed) H. J. McDermith M.D.

12/14/21 (Address) Baybrin Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spnce.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec 18 1921

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Lystil St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59432

CERTIFICATE OF DEATH.

153

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 N Baltimore ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Bass

(Residence in Baltimore: No. 1612 N Balto St.; ....yrs., 2 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept 28, 1921.
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James R. Bass

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Margaret Haughton

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edyth Rust

(Address) 2016 N Charles St

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1921, to Dec 16 1921, that I saw her alive on Dec 16 1921, and that death occurred, on the date stated above, at 5-25 p.m.

The CAUSE OF DEATH* was as follows:

I. Pneumonia

.....

.....

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Weakness

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph E. Sasse M. D.

Dec 16, 1921 (Address) 1520 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Olivet	Dec 19..., 1921
20-UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1835 W. PRATT STREET.	ADDRESS

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Craig)

Spmc—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59433

D 59433

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 508 Robert ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Craig

(a) RESIDENCE. No. 508 Robert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie Craig

6 DATE OF BIRTH (month, day, and year): Apr 29 1887

7 AGE: Years 34 Months 11 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver 523

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm H. Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Addie Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Addie Gibson (Address) 508 Robert St

15 Filed: Dec 19 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/1X 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/2 , 1921 , to 12/1X , 1921 , that I last saw h— alive on 12/1X 1921 , and that death occurred, on the date stated above, at 9:50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. X mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkett , M. D.

, 19 (Address) 739 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 17 1921
20 UNDERTAKER	ADDRESS
Chas G. Bailey	142 Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 59434

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Arlington Ave (Govans) ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Farland Mitchell

(a) RESIDENCE No. 701 Arlington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Oct. 28-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Public School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Marcellus A. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER: Henrietta E. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Elnora L. Mitchell (Address) 701 Arlington Ave Govans

15 Filed ..... 19 Robert P. Harriss, Burial Permit Clerk. Registrar

C 17121

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1920, to Dec 16, 1921,

that I last saw h[illegible] alive on Dec 15, 1921,

and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH was as follows:

Brights Disease

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) [illegible] M. D.

Dec 17 1924 (Address) 1107 Lexington Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Dec 19 1921

20 UNDERTAKER: Forkler & Forkler E. J. F. — ADDRESS: 739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT COMPLETELY. PHYSICIAN'S name and date of attendance should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59435 D 59435

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 S. Bethel ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Bernard Wilson

(a) RESIDENCE. No. 220 S. Bethel ST., 3 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 7. 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Minnie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Theodore White 235 Wolf St

15 Filed DEC 17 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15. 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 14. 1921, to Dec 15. 1921, that I last saw h[illegible] alive on Dec 15. 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis
Acute Pericarditis

Febricula Pleurisy (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary T B (duration) chronic 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam. & Autopsy

(Signed) A. F. Fis, M. D.

Dec 15 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 18. 1921
20 UNDERTAKER	ADDRESS
Theodore White 113	S. Wolf St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59436

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital or on way Hurl to St.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James Huff.

(Residence in Baltimore: No. 1416 N Pulton St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid.

6-DATE OF BIRTH Unknown, 1857
(Month) (Day) (Year)

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Huff

(Address) N 4

15- Robert F. [illegible]

Filed ....., 191.... Registrar.

Burial Permit Clerk.

(6 17 1921)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Ins. Dr. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

Dec 16, 1921 (Address) 1657 Bruce

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, Dec 19 1921

20-UNDERTAKER Geo H Holland

ADDRESS 1631 Vernon Ave

4-6.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59437

CERTIFICATE OF DEATH.

104-091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 905 Ramsay St. ST. 21 WARD)

2-FULL NAME William G Cooke

(a) RESIDENCE. No. 905 Ramsay St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 9 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Cooke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Lillie Wickenden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr John Cooke
(Address) 905 Ramsey St.

15 1921 Robert P. Harrison
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16/21 19

17 I HEREBY CERTIFY, That I attended deceased from 12/13/21, 19, to 12/16/21, 19,

that I last saw h— alive on 12/16/21, 19,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) thirty yrs. mon. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Leonard Tenney, M. D.

12/17, 1921 (Address) 1100 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec. 17, 1921
20 UNDERTAKER John J Cowan & Son.	ADDRESS 901 Hollins St

DEC 17 1921

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST be stated EXACTLY. PHYSICIANS should be careful to state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastr Enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59438

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5037 Washington ST.: 7 WARD)

2-FULL NAME Lenita M. Lucas

(a) RESIDENCE. No. 327 Maryland Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mns. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21-1917

7 AGE — Years: — Months: 8 — Days: 26 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None H.W.D.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Catherine Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Charles Lucas.
(Address): 327 Maryland Ave

15 Filed Dec 17 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 19.., to Dec 16, 1921, that I last saw h[illegible] alive on Dec 16, 1921, and that death occurred, on the date stated above, at 4 H m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lovell, M. D.

12/16, 1921 (Address) 413 N. Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Dec 17 1921
20 UNDERTAKER	ADDRESS
Geo. G. Cook	[illegible]

DC 1 71921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 59439

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

63 D 59439

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. Edmondson Ave near Elsinore ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sue B Cook.

(Residence in Baltimore: No. Edmondson Ave near Elsinore St.: 47 yrs. 0 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Nov (Month) 17 (Day), 1874 (Year)

7 AGE: 47 yrs. 0 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John T Timmins

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Fannie A Conolle

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs M B Schumeborn

(Address) Catonsville Md

15 Robert P. Harrison,

Filed ..... 191 ..... Burial Permit Clerk. REGISTRAR

DEC 17 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 16 (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1921 to Dec 16 1924.
that I saw her alive on Dec 15 1924.
and that death occurred, on the date stated above, at 3, 50 a m.
The CAUSE OF DEATH* was as follows:

Multiple Myeloma

(Duration) — yrs. 6 mos. — ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Marshall B Worst M. D.

Dec 16, 1924 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL: Lorraine Park Co — DATE OF BURIAL: Dec. 19" 1924

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 603 N. Bolton St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH ONE ENTRY IN EACH SPACE. THIS IS A PERMANENT RECORD.

tuberculosis

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train — accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59440

CERTIFICATE OF DEATH.

1720 D 59440

1-PLACE OF DEATH
CITY OF BALTIMORE: No. Mercy Hospital ST.; 4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Isabey.

(a) RESIDENCE. NO. 404 St. Paul ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE: Years 63; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10 NAME OF FATHER: Terence —
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Bridget —
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Gurrys
(Address) 1106 Eastland St.

15 Filed ... 1921 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Dec 16, 1921, that I last saw her alive on Dec 16, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) (5) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Urine & Symptoms

(Signed) John F. Dowd M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral
DATE OF BURIAL: Dec 19 1921

20 UNDERTAKER: Martin Tuskey & Son
ADDRESS: 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 59441

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59441

CERTIFICATE OF DEATH.

109

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital WARD)

2-FULL NAME John Wild

(a) RESIDENCE. NO. 816 E. Third St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ann Margaret Wild

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED 867

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Gd. Run Thro Bowery.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Wild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown Dec 15, 21, 19

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Wild
(Address) 816 Robert St Harrison.

15 Filed 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1921, to Dec 15, 1921, that I last saw h alive on Dec. 15, 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 12 '21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Frank C. Hearns, M. D.

(Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 19 19
20 UNDERTAKER Lilly and Zeiler.	ADDRESS 403 S. Wo

THIS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59442

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59442

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 640 S. Ensley St. ST.: 1 WARD)

2-FULL NAME Patrick J. Lynch

(a) RESIDENCE. NO. 640 S. Ensley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Hanah Kelly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Edward Lynch
(Address) 640 S. Ensley St.

15 Filed ..... 19 Robert P. Harrison
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1931

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1931, to Dec 15, 1931, that I last saw h[illegible] alive on Dec 15, 1931, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Dis. Pulp Tuberc Meningeal
Atelectasis Foramen Ovale Patulum

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Otitis Interna Acute

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Parker, M. D.

(Address) 322 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 17 1931
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe St.

NOTE.—WRITE PLAINLY WITH LEAD PENCIL OR PEN—INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59443

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

78D 59443

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 3833 Clifton ave St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Fulton Moore

(Residence in Baltimore: No. 3833 Clifton ave, St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~ OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: May 27 (Month) (Day), 1888 (Year)

7-AGE: 33 yrs. 5 mos. 18 ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Kentucky

PARENTS

10-NAME OF FATHER: William H Moore

11-BIRTHPLACE OF FATHER (State or country): Kentucky

12-MAIDEN NAME OF MOTHER: Lucy Colgan

13-BIRTHPLACE OF MOTHER (State or country): Kentucky.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Junia Moore
(Address) 3833 Clifton Ave

15

Filed Dec 16 1921 Robert P. Harrison, REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 15 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 7, 191 to Dec 15 1921.
that I saw h~~im~~alive on Dec 15, 1921.
and that death occurred, on the date stated above, at 1.30 p.m.
The CAUSE OF DEATH* was as follows:

Tuberculosis
of Lungs
(Duration) 5 yrs. mos. ds

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) R. L. Knott M. D.
Dec 15, 1921 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec 17, 1921

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS: 108 W. NORTH AVE.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

D 59444

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59444

CERTIFICATE OF DEATH.

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Bayview Hospital St. 25 WARD) REGISTERED No. C 89

2 FULL NAME Jacob Doe

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Unknown

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 76 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bayview Hospital

(Address) Baltimore

15-

Filed ....., 191....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

DEC 1 1921

18256

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Insanity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Lyon Smith M. D.
(Coroner)

Dec 16 1921, (Address) 1000 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER: Commissioner Health.

ADDRESS DEC 1 1921

Per. Wm. E. WOODALL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59445

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 Schott Court. ST. 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Jones. (C)

(Residence in Baltimore: No. 1112 Schott Court. St.; 30 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH, Do not know. (Month), (Day), 1 (Year)

7-AGE, 65 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER: Benjamin Sawyer. (C)

11-BIRTHPLACE OF FATHER (State or Country): Maryland.

12-MAIDEN NAME OF MOTHER: Do not know.

13-BIRTHPLACE OF MOTHER (State or Country): Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Jones. (C) son.

(Address) 1112 Schott Court.

15-

Filed DEC 17 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15th. 1921., 191... (Month), (Day), (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) C. M. Kemp M. D. (Coroner.)

Dec 16th, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Ct — DATE OF BURIAL, Dec 16 —, 19 21

20-UNDERTAKER I. L. Brown & Son — ADDRESS 108 W Monty St

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stuermer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59446

CERTIFICATE OF DEATH.

79

D 59446

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 210 S. Bowdoin St. Ward)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard D. Stuermer

(Residence in Baltimore: No. 322 S. Bowdoin St. 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	white	Married

6-DATE OF BIRTH. Sept. 16th, 1874
(Month) (Day) (Year)

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman 080
(b) General nature of industry, business, or establishment in which employed (or employer): Continental Can Co.

9-BIRTHPLACE. (State or Country) Germany

PARENTS.

10-NAME OF FATHER. Adolph Stuermer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Barang

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Stuermer

(Address) 322 S. Bowdoin St.

15- Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Knox Tandy M. D.
(Coroner.)

12-17-21, 191.. (Address) 9 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	12-18-, 19 21
20-UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59447

CERTIFICATE OF DEATH.

120 D 59447

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3716 Hickory Ave. ST., 43 WARD)

2-FULL NAME William L. Campbell

(a) RESIDENCE NO. 3716 Hickory Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Campbell

6 DATE OF BIRTH (month, day, and year) Oct. 16 1863

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
58	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer) American Can Co.

(c) Name of employer Retired 3 years.

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Maryland

PARENTS

10 NAME OF FATHER James H. Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Priscilla Millard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Annie Campbell

(Address) 3716 Hickory Ave

15 DEC 18 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1921, to Dec 16, 1921, that I last saw him alive on Dec 16, 1921, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1932 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jacobus, York Co. Pa. DATE OF BURIAL Dec 20 1921

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Hallo Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59448

CERTIFICATE OF DEATH.

D 59448

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hosp—

CITY OF BALTIMORE: (No. ST.: 33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest L. Justin

(a) RESIDENCE. No. Philadelphia Pa ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 6 ds. How long in U. S., if of foreign birth? — yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Ella W. Justin

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Director of Public Welfare

(b) General nature of industry, business, or establishment in which employed (or employer) Philadelphia Pa.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Record
(Address) St. Agnes Hospital

15 Filed DEC 18 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-12 1921, to 12-18 1921.

that I last saw him alive on 12-18-21 19

and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Carc. Breast — Metastasis to axilla —

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis — myocardial failure

(duration) yrs. mos. 12 hrs —

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-17-21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. G. Caldwell, M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila Pa	12/18 1921

20 UNDERTAKER Chas. S. Evans & Son ADDRESS 1100 N. Royal ave

INK—THIS IS A LEGAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 59449

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bridgley St ...ST.. 25 ...WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Daily

(Residence in Baltimore: No. Bridgley St ...St.; 5½ yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	Col'd	Single

6-DATE OF BIRTH, ...May... (Month) ...(Day) 1854 (Year)

7-AGE,	If LESS than 1 day,
37 yrs. 11 mos. ...ds.	...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...none...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Randolph Daily

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary E. Lucas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Daily

(Address) Bridgley st

15- DEC 18 1921 ROBERT R. KRAUTER,
Filed ..., 191... Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...12... (Month) ...14... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Dec 12 1921, that I saw h[er] alive on Dec 12 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

...

...

... (Duration) ...yrs. 4 mos. ...ds.

CONTRIBUTORY (Secondary) Exhaustion

... (Duration) ...yrs. ...mos. ...ds.

(Signed) Harry Steele M. D.

12-14, 1921 (Address) Walthers

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
Mt Auburn Cemetery	
20-UNDERTAKER	ADDRESS
Frank Hopkins	

R. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59450

D 59450

CERTIFICATE OF DEATH.

78

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2418 Buchanan ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Jones

(a) RESIDENCE. No. 2418 Buchanan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Elsie Jones.

6 DATE OF BIRTH (month, day, and year) May 16, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - 040

(b) General nature of industry, business, or establishment in which employed (or employer) Cement-Sand Etc.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER John Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis

12 MAIDEN NAME OF MOTHER Morgunte Halladay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

14 Informant: Elsie Jones.
(Address) 2418 Buchanan

15 Filed DEC 18 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to Dec 14, 1921, that I last saw h[illegible] alive on Dec 14, 1921, and that death occurred, on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tubrculosis

(duration) yrs. 8 mos. ? ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum.

(Signed) Wm. A. Bright M. D.

(Address) 1209 [redacted] Johnson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cem.	Dec 18 '21
20 UNDERTAKER David Handley	ADDRESS 518 N. Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 B 59451

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 506 Ogston ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Fowler

(a) RESIDENCE. NO. 506 Ogston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE — Years: 60 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sells Matches

(b) General nature of industry, business, or establishment in which employed (or employer): D 45

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thos. Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Caroline Voss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs L. E. Fagan 132 N. Dolphin St

15 Filed DEC 18 1921 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 13 1921 to Dec 15 1921.

that I last saw him alive on Dec 15 1921.

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Casey M. D.

, 19 (Address) 522 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Dec 15 1921

20 UNDERTAKER: Samuel E. Kemsley — ADDRESS 518 N Bridal

N. B.—WHITE PLAINLY. WITH CARE AND ATTENTION. THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

) 59452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

640 59452

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 R Durham ST.; 6 WARD)

2-FULL NAME Anna Paul

(a) RESIDENCE. NO. 19 R Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antone Paul

6 DATE OF BIRTH (month, day, and year) Mar 6-1851

7 AGE: 70 Years; Months 4; Days 1; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemian

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Antone Paul
(Address) 19 R Durham st

15 Filed DEC 18 1921 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18 1921 to Dec 17 1921, that I last saw h[e] alive on Dec 16 1921, and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. Rypacek, M. D.

12/19/21 (Address) 1801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 19 1921

20 UNDERTAKER Thos C. Kirkley

ADDRESS 2334 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Eurich

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59453 D 59453

CERTIFICATE OF DEATH.

Hamilton 64

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 38 Harford St. 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Eurich.

(Residence in Baltimore: No. 38 Harford Rd St.; yrs. 64 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Oct 24, 1860 (Month) (Day) (Year)

7-AGE, 61 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer): 054

9-BIRTHPLACE, (State or Country), Balto Md,

PARENTS.

10-NAME OF FATHER, Peter Eurich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Eschbach

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Eurich

(Address) 38 Harford Road

15- Filed DEC 18 1921 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

12-16, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem. DATE OF BURIAL, Dec 19, 1921.

20-UNDERTAKER H. Sander Son ADDRESS 1310 Fremont Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59454

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 915 Hunter St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ellen J Dodsan

(Residence in Baltimore: No. 915 Hunter St. 40 St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col.	Widow

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establisment in which employed (or employer): House Work

9-BIRTHPLACE, (State or Country). Live in Balt 40 years St Marys County

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nancy Christian

(Address) Mt Olivet Balto Co

15- DEC 18 1921 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Kirk Insley M. D. (Coroner.)

12-16, 1921. (Address) 4 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, Dec 19 19....

20-UNDERTAKER Mrs Robert A Elliott — ADDRESS 725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59455

CERTIFICATE OF DEATH.

19 D 59455

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1048 Cathedral St., 8th Ward)

2-FULL NAME Eliza Jane Keene

(a) RESIDENCE. No. Same St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conchester Co Md

PARENTS

10 NAME OF FATHER Henry Shelton

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Eliza Keene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emilie V Bellison

(Address) 104 Caledon Road

15 DEC 18 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15 1915 to Dec 15 1921.

that I last saw h alive on 12-15 1921.

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cardiac degeneration

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J Morgan, M. D.

, 19 (Address) 1622 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Sanitarium Patient

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Memorial Cemetery Dorchester Co Md.

DATE OF BURIAL: Dec: 20th 1921

20 UNDERTAKER: Chas H. Dill

ADDRESS 3109 Fredk Ave.

N. B.—WRITE PLAINLY, WITH INK AND IN INDELIBLE PENCIL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59456

CERTIFICATE OF DEATH.

64

D 59456

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Callow Av ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harris Goldstein

(Residence in Baltimore: No. 2303 Callow av St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) 7 (Day), 1851 (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Lord Goldstein

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mollie Timins

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Goldstein

(Address) 2303 Callow ave

15- DEC 18 1921 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 16 1921, that I saw him alive on Dec 16 1921, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY ~~Atero Sclerosis~~, (Secondary)

(Duration) 4 yrs. mos. ds.

(Signed) Joseph E Pichman M. D.

Dec 17, 1921. (Address) 1516 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Southern ave — DATE OF BURIAL, Dec 18, 1921

20-UNDERTAKER Max Furman — ADDRESS 1276 Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59457

8 | D 59457

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2910 O'Donnel ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abarany, Dasset (Bassin)

(a) RESIDENCE NO. 2910 O'Donnel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? 17 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	68			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Retired Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mario Basset

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 14th E. Balto. St

15 Filed DEC 18 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-18 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1921, to Dec. 18, 1921,

that I last saw him alive on Dec. 17, 1921,

and that death occurred, on the date stated above, at 5A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Charles S. Levy, M. D.

12-18 1921 (Address) 2456 Callow Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Rosedale	12-8 1921
20 UNDERTAKER	ADDRESS
Jack Lewis,	14th E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Med 2337 Nov 24

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. Tho contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage. No further history.

Alban

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59458 D 59458

CERTIFICATE OF DEATH.

X 45

REGISTERED NO.

1-PLACE OF DEATH University Hospital -

CITY OF BALTIMORE: (No. Lombard & Greene ST.: H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maggie alban -

(a) RESIDENCE. NO. Cockeysville, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (Husband of) (or) Wife of W. H. alban

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework - 031

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Silas Parks - Md -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Judge

12 MAIDEN NAME OF MOTHER (?) Johnson - Md -

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant W. H. alban Cockeysville Md
(Address)

15 Filed DEC 18 1921, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-13, 1921, to 12-16, 1921, that I last saw her alive on 12-16-21, 1921, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

General saturation of pelvic organs

(duration) ? yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Peritheleial Sarcoma ? of pelvic organs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of 12-15-21

Was there an autopsy? no -

What test confirmed diagnosis? Clinical Findings

(Signed) L. H. Brumbrell, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Joseph M. E. Church	Dec 19 21
20 UNDERTAKER	ADDRESS
W. C. Brooks	Sparks Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

First organ involved not known. All pelvic organs involved

D 59459 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59459

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Washington Ave & Fort St. 27 Ward)

2-FULL NAME Thomas G Bloom

(Residence in Baltimore: No. Washington Ave & Fort St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Oct 12, 1863 (Month) (Day) (Year)

7-AGE: 58 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Co.

PARENTS.

10-NAME OF FATHER: David Bloom

11-BIRTHPLACE OF FATHER (State or Country): Carroll Co, Md

12-MAIDEN NAME OF MOTHER: Bridget Burns

13-BIRTHPLACE OF MOTHER (State or Country): Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Bloom

(Address) Washington Ave & Fort St

15-DEC 18 1921 ROBERT R. KRAUTER, Filed ....., 191.... Clerk.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Abscess of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Howard M. D.

(Coroner) Dec 19, 1921 (Address) 1732 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL: Druid Ridge — DATE OF BURIAL: Dec 19, 1921

20-UNDERTAKER: A S Marshall — ADDRESS: 3614 Fait Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 59460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59460

CERTIFICATE OF DEATH.

150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 Hilton St. ST.: 15 WARD)

2-FULL NAME Edward Sauerwald.

(a) RESIDENCE. NO. 334 Hilton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-22-21

7 AGE — Years — Months — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city

PARENTS

10 NAME OF FATHER: Edward L. Sauerwald.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Clara Bloom.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Edward Sauerwald
(Address): 334 Hilton

15 Date Received: DEC 18 1921

ROBERT H. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-17 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-22. 1921, to 12-17. 1921, that I last saw h[illegible] alive on 12-17. 1921, and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease.

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. H. Miller, M. D.

12/19/21 (Address) 2757 Wilmot ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Dec 19 21

20 UNDERTAKER: Martin Eichler & Sons — ADDRESS: 1531 N Paths

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59461

CERTIFICATE OF DEATH.

D 59461

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U. O. D. St.: 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick A. Hess

(Residence in Baltimore: No. 2051 Pennsylvania Ave. St.: 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, Dec. 4 1895
(Month) (Day) (Year)

7-AGE, 26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) 034

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, August Hess

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Mockel

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. A. Hess

(Address) 2051 Pennsylvania Ave,

15-

FILED DEC 18 1924 ROBERT R. KRAUTER,

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Jacobs (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver shot wound of chest.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Homicide

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D.
(Coroner)

Dec. 17, 1924 (Address) 2822 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

2051 Pennsylvania Ave.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Brunswick N J — DATE OF BURIAL, Dec. 18, 1924

20-UNDERTAKER Martin Fahey's Sons — ADDRESS 1827 W. Balto St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59462

CERTIFICATE OF DEATH.

13 VD 59462

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S Rose ST., 1 WARD)

2-FULL NAME Anna Ella Grouling

(a) RESIDENCE NO. 802 S Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George A Grouling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ella Drash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Charles Grouling

(Address) 802 S. Rose St

15 Filed DEC 18 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Dec 17, 1921, that I last saw her alive on Dec 17, 1921, and that death occurred, on the date stated above, at 825 Pm.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

12/18, 1921 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
MR Mount Com.	12/18/21 19
20 UNDERTAKER	ADDRESS
Wm Cook	525 E Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59463

CERTIFICATE OF DEATH.

D 59463

19 REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 5423 (Street) Park Heights Ave. (St.) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Irene Lynch

(a) RESIDENCE: No. 5423 Park Heights Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Irish

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Timothy J. Lynch.

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years: about 75 | Months: — | Days: — | If LESS than 1 day, ... hrs. or ... min.: —

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Housework.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS
10 NAME OF FATHER: Patrick Lennon
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Duffy
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. M. W. Mullen 5423 Park Heights Ave.

15 [illegible]

DEC 18 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1921, to Dec 16, 1921, that I last saw h[illegible] alive on dec 16, 1921, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Kidneys

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Nurse Chronic Heart Dis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) W. Bolley MD M. D.

12/19 1921 (Address) Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 12/19 1921

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59464

CERTIFICATE OF DEATH.

170 D 59464

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 Aull St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Ursula Annen

(a) RESIDENCE. No. 644 Aull St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Annen

6 DATE OF BIRTH (Month, day, and year): October 18th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Bolivar Md

PARENTS

10 NAME OF FATHER: Lewis Kratzer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bolivar Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Ellen Annen
(Address) 644 Aull St

15 Filed DEC 18 1921, 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 23/21, 19 21, to Dec 16th, 19 21, that I last saw ~~her~~ alive on Dec 16th, 19 21, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Contributory

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) F. W. Humpstone M.D. M. D.

12/16/21 19 (Address) 4016 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Grave	Dec 19 1921
20 UNDERTAKER	ADDRESS
Robt S. Lemmon Inc	1 x x x N. Bway

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59465

CERTIFICATE OF DEATH.

32 D 59465

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2614 E. Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Gibson

(a) RESIDENCE No. 2614 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Georgie May Gibson

6 DATE OF BIRTH (month, day, and year): June 17 1883

7 AGE — Years: 38 — Months: 5 — Days: 29 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stationary Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Crown Cork & Seal Co

9 BIRTHPLACE (city or town) (State or country): Kent Co Md

PARENTS

10 NAME OF FATHER: John Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Georgie May Gibson

(Address) 2614 E Monument St

15 Filed DEC 18 1921 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1920, to Dec 16, 1921, that I last saw h alive on Dec 15, 1921 and that death occurred, on the date stated above, at 10.55 a.m.

The CAUSE OF DEATH* was as follows:

Psoas abscess (Tuberculous)

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo Seymour, M. D.

12/19 1921 (Address) 2528 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Dec 19 1921

20 UNDERTAKER: Wm J Hickmans Sons — ADDRESS: North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

59466 D 59466

HEALTH DEPARTMENT—CITY OF BALTIMORE

59466 D 59466

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 9th St. Fairfield ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Walker.

(Residence in Baltimore: No. 9th St. Fairfield St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ..., 1849 (Month) (Day) (Year)

7-AGE, 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Sterling Walker

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Walker

(Address) 9th & Fairfield

15-

Filed ..... 191.....

DEC 18 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec-6-1921, to Dec-17-1921, that I saw him alive on Dec-10-1921, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows: Valvular heart lesion

.....

.....

.....

.....(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Subacute bronchitis

.....(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) W. T. Coleman M. D.

Dec 18, 1921 (Address) 323 E. McCulloh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 7 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Va.

19-PLACE OF BURIAL OR REMOVAL, Dr. DATE OF BURIAL, Dec. 19 1921

20-UNDERTAKER Mrs R. A. Elliott ADDRESS 1725 Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59467 D 59467

091 9 59467 D 59467

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Sydenham Hospital WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Duncan

(a) RESIDENCE. NO. 1819 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Robert F Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Alma Vancuin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md.

14 Informant (Address) Robt Duncan Sr 1819 Hanover St

15 FILED DEC 18 1921 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1921, to Dec 17, 1921, that I last saw alive on Dec 17, 1921, and that death occurred, on the date stated above, at 7:35 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal tonsillar & pharyngeal (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical pos.

(Signed) Bullagan — M. D.

(Address) Sydenham Hospital Dec 18 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Dec 18 1921

20 UNDERTAKER Margaret D Flynn ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 9-091 ✓

D 59468

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Sydenham Hospital ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Downey.

(a) RESIDENCE. NO. 512 West Lexington WARD. Newark Del

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Newark. Del.

PARENTS

10 NAME OF FATHER: John Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co. Md.

12 MAIDEN NAME OF MOTHER: Sallie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Del.

14 Informant: John Downey
(Address): 512 W. Lexington.

15 Filed DEC 19 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1921, to Dec 18, 1921, that I last saw h[illegible] alive on Dec 18, 1921, and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) [illegible] M. D.

1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Dec 19 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Potts. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

SAUERS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59469

CERTIFICATE OF DEATH.

45 D 59469

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Mosher St. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Frederick Sauers

(a) RESIDENCE NO. 1312 Mosher St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie R. Sauers

6 DATE OF BIRTH (month, day, and year) Oct. 4th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of Industry, business, or establishment in which employed (or employer) B and O R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George F. Sauers

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Jennie Sauers
(Address) 1312 Mosher St.

15 Date DEC 19 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16th 19 21

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Dec 16th, 1921, that I last saw him alive on Dec 16th, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of bladder

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Early Sept.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Lehnert M. D.

Dec. 17th, 19 (Address) 211 N Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 19th 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

26.00

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59470

D 59470

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 332 S Robinson ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Duvall

(a) RESIDENCE No. 332 S Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Duvall

6 DATE OF BIRTH (month, day, and year) Sept 22 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John T. Lewis

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rosella Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Catherine Duvall (Address) 332 S Robinson St

15 Filed DEC 19 1921 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1921, to Dec 16, 1921,

that I last saw him alive on Dec 14, 1921,

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Harris M.D.

12/17, 1921 (Address) 2600 Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Dec 20 1921
20 UNDERTAKER	ADDRESS
J. Sander Sons	1710 Eland St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 59471

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N Milton Ave ST., 6 WARD)

2-FULL NAME Frederick L. Nelson Sr.

(a) RESIDENCE NO. 121 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: HUSBAND of Katherine Nelson

6 DATE OF BIRTH (month, day, and year): Jan. 10, 1848

7 AGE: Years 73 Months 11 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Peter Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Franz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Katherine Nelson (Address) 121 N. Milton Ave

15 Filed DEC 19 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1921, to same day 1921 that I last saw him alive on 10 10 a.m. Dec 16 1921, and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Taylor, M. D.

, 19 (Address) 1192 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Dec 19 1921

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 59472

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1807 Windsor Mill Road (ST.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Hallamyer

(a) RESIDENCE (No.) 1807 Windsor Mill Road (ST.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec. 27 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank L. Hallamyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary A. Hollmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Frank L. Hallamyer (Address) 952 N. Edeu St

15 Filed DEC 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921 to Dec 17 - 1921.

that I last saw him alive on Dec 17, 1921

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. Exam.

(Signed) John A. Husband M. D.

(Address) Dec 18-1921 1219 Eutaw Place

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 21 1921
20 UNDERTAKER	ADDRESS
Henry Horck Son	1301 E Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59473

CERTIFICATE OF DEATH.

64 D 59473

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3132 Baker ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Ann Ross

(Residence in Baltimore: No. 3132 Baker St. St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 14 (Day), 1866 (Year)

7-AGE, 55 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Phila. Pa

PARENTS.

10-NAME OF FATHER, Jas Pierce

11-BIRTHPLACE OF FATHER (State or Country), Md. Elkton.

12-MAIDEN NAME OF MOTHER Lydia Clendaniel

13-BIRTHPLACE OF MOTHER (State or Country), Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emily Krul

(Address) Sister - 3132 Baker

15-

Filed DEC 19 1921, 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 15th 1921 to Dec 15th 1921.

that I saw h[illegible] alive on Dec 15th 1921

and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Several hours

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Indigestion

Several hours

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. L. Parker M. D.

12-16, 1921 (Address) 3123 W. Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. In the City ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Consultation

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet — DATE OF BURIAL, 12-19, 1921

20-UNDERTAKER Earl B Hardt — ADDRESS 115 E Mt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59474 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59474

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 Jefferson ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice G. O'Donnell

(a) RESIDENCE. No. 2708 Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of ~~HUSBAND~~ John A. O'Donnell

6 DATE OF BIRTH (month, day, and year) Oct 18/86

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Richard J. Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice A.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant John O'Donnell (Address) 2708 Jefferson

15 DEC 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1921, to Dec. 17, 1921, that I last saw h alive on Dec. 17, 1921, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Cusano, M. D.

Dec. 18, 1921 (Address) Inn Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL: Dec 20 1921

20 UNDERTAKER: Philip Herrig ADDRESS 206 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59475

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4409 Reisterstown Rd St.; 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Malcolm Epstein

(Residence in Baltimore: No. 4409 Reisterstown Road St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S

6-DATE OF BIRTH, Nov 20, 1921 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Ellis Epstein

11-BIRTHPLACE OF FATHER (State or Country) Russia Balto md

12-MAIDEN NAME OF MOTHER Dorothy Harris

13-BIRTHPLACE OF MOTHER (State or Country), Russia Ky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellis Epstein

(Address) 4409 Reisterstown Rd

15- Dated DEC 19 1921 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Carbolic acid poisoning Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Sherwell M. D. Coroner.

Dec 19, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 12/21, 1921

20-UNDERTAKER Jack Levin

ADDRESS 1411 Druid

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—MAT—1500 Blks.

D 59476

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

53 D 59476

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 409 East 27th ST., 12 WARD)

2-FULL NAME Mary E. Carroll

1a) RESIDENCE NO. 409 East 27th ST., WARD 12
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

6 If married, widowed, or divorced (or) WIFE of Michael Carroll

6 DATE OF BIRTH (month, day, and year) Dec - 1844

7 AGE: Years 77; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in wh'h employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Field

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Field

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Alfred E. Carroll
(Address) 409 E - 32nd St

15 Filed DEC 19 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25 1921 to Dec. 19 1921.

that I last saw her alive on Dec. 16 1921.

and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Syncope

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hodgekiss Illness (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Signs & Symptoms

(Signed) Wm J. Gilbert M. D.

, 19 (Address) 4151 Cedarcroft Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL 12/20 19 1

20 UNDERTAKER: Wolhaupter Co's

ADDRESS 502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Schuman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59477 — 79 D 59477

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 501 Ravenwood St. 27 WA. (D)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Schauman.

(Residence in Baltimore: No. 501 Ravenwood St. 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	Married

6-DATE OF BIRTH. Jan 11, 1877
(Month) (Day) (Year)

7-AGE. 44 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Plumber
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER. John Schuman

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth ?

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Schumann

(Address) 501 Ravenwood Av.

15-

Filed DEC 10 1901 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 17, 1911
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and thereon, and from the evidence obtained by said Inquest, and Inquest found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hunt Smeley M. D.
(Coroner)

12-17, 191... (Address) 19 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mo. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore	12/19 1911
20-UNDERTAKER William Cook	ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

59478

CERTIFICATE OF DEATH.

X 40 D 59478

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospl. ST.: 11 WARD)

2-FULL NAME Mathias Kiefer

(a) RESIDENCE. No. Edmonson and Rolling Rds ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Kiefer

6 DATE OF BIRTH (month, day, and year) April 12 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chicken. 786

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Kiefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Rock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Rock Kiefer

(Address) 1201 W. Fayette St

15 Filed DEC 19 1921 ROBERT R. KNAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5/21, to Dec 17/21, 19..., that I last saw him alive on Dec 17/21, 19..., and that death occurred, on the date stated above, at 7P.M.

The CAUSE OF DEATH* was as follows: Tuberculosis of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Pancreas

(duration) about yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis? Clinical findings

(Signed) J. A. Tompkins, M. D.

, 19 (Address) 1 W. Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Pompton Lakes N.J. Dec. 20 '21

20 UNDERTAKER John O. Mitchell

ADDRESS 2017 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

59479

HEALTH DEPARTMENT—CITY OF BALTIMORE

59479

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 St Peter ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Wichard

(a) RESIDENCE. NO. 724 St Peter ST. 21 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Gustav Wichard

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alma Fitzpatrick
(Address) 724 St Peter St

15 Filed DEC 19 1921, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921, to Dec 17, 1921.

that I last saw h— alive on Dec 16, 1921.

and that death occurred, on the date stated above, at 2 a, m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grundlach, M. D.

12/19/21 (Address) 517 Front St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 19th 1921

20 UNDERTAKER — ADDRESS

Geo Leimbach & Son — 647 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59480

CERTIFICATE OF DEATH.

64 D 59480

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander S. Jackson

(Residence in Baltimore: No. 2763 W. Fairmount St.: yrs. 62 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Aug. 17, 1859 (Month) (Day) (Year)

7-AGE: 62 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Savings Bank,

9-BIRTHPLACE, (State or Country): On Atlantic Ocean Enroute to U.S.A.

PARENTS.

10-NAME OF FATHER: Henry Jackson

11-BIRTHPLACE OF FATHER (State or Country): Ireland.

12-MAIDEN NAME OF MOTHER: Mary Dunmeas

13-BIRTHPLACE OF MOTHER (State or Country): Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary V. Jackson

(Address) 2763 W. North Ave.

15-

Filed....., 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit

DEC 19 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D. (Coroner.)

Dec. 17, 1921 (Address) 2702 Eutaw Place,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hospin the of death.....yrs.....mos. 1 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? ar Walbrook Junction.

Former or usual residence 2763 W. North Ave.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 12/20, 19 21

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 V D 59481

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 S Chapel ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene M. Filinski

(a) RESIDENCE. NO. 529 S Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 27 ds. How long in U. S., if of foreign birth? yrs. 5 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 COLOR OR RACE: wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 22 / 21

7 AGE — Years: — Months: 5 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Filinski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Veronika Grubowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): John Filinski Father 529 S. Chapel St.

15 DEC 19 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec, 18 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 21 to Dec 18 21

that I last saw her alive on Dec 17 21

and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Spencer M. D.

(Address) 801 N Kenwood Ave

Dec 18 21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. — DATE OF BURIAL: Dec 20, 1921

20 UNDERTAKER: M. J. Sadowski — ADDRESS: 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

Fabiszak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59482

CERTIFICATE OF DEATH.

D 59482

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2022 Fountain St.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Fabiszak

(a) RESIDENCE. No. 2022 Fountain ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Sgle.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sgle.

6 DATE OF BIRTH (month, day, and year): Apr 27 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory worker

(b) General nature of industry, business, or establishment in which employed (or employer): Co-Co. Co. Co 086

(c) Name of employer: Pkg.

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph Fabiszak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Wesolowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mary Fabiszak
(Address): 2022 Fountain

15 DEC 19 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 - 1921.

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 21, to Dec 17, 21,
that I last saw h[illegible] alive on Dec 17, 21,
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Suicidal.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dwl house

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Undertaker

(Signed) A. Knox Insley, M. D.

19 (Address) 2338 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	Dec. 21. 1921.
20 UNDERTAKER: M. J. Sadowski.	ADDRESS: 706 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59483 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 709 N Fremont Ave St. 17 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hanny R. Ray

(Residence in Baltimore: No. 709 N. Fremont Ave St. 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Unknown (Month), (Day), 1861 (Year)

7-AGE, 60 yrs. about mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Ray

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Emily Wells

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Eliz. Ritchie

(Address) 709 N. Fremont Ave

15- Filed ....., 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

DEC 19 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Duration yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Duration yrs. mos. ds.

(Signed) J. C. Ritchie M. D.
(Coroner.)

1921 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Dec 20 1921
20-UNDERTAKER	ADDRESS
Wm J Heitkuer Sons	North Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59484

CERTIFICATE OF DEATH.

66 D 59484

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 E Fairmount St.; Ward) 1st

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina C McLaurine

(a) RESIDENCE. No. 2117 E Fairmount St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Edward L M Laurine

6 DATE OF BIRTH (month, day, and year) March 6 186x

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Parts Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward L M Laurine

(Address) 2117 E Fairmount St

15 Filed DEC 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1921 to Dec 18 1921

that I last saw h alive on Dec 17 1921

and that death occurred, on the date stated above, at 4. a m.

The CAUSE OF DEATH* was as follows:

Asteriá Sclerosis

Left Upper Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Evidence

(Signed) J. C. Blades M. D.

(Address) 1437 N Bway

Dec 19 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 21 1921

20 UNDERTAKER Philip Tanner ADDRESS 1 & 2 N Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59485 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 41 D 59485

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 427 Rosedale ST.; W WARD)

2-FULL NAME Loretta M Messer

(a) RESIDENCE. No. 427 Rosedale ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas F Messer

6 DATE OF BIRTH (month, day, and year) Nov 5 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Bernard Fallon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Yohnnnn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas F. Messer

(Address) 427 Rosedale Ferndale

15 Filed DEC 1 1921 19.. Robert P. Harrison, Jr. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 1920, to Dec 17 1921, that I last saw her alive on Dec 17 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Recto-Vaginal Septum

(duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 20. 20

Was there an autopsy? No

What test confirmed diagnosis? X Ray + operation.

(Signed) Howard W Jones, M. D.

Dec 19 (Address) 222 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 20 1921
20 UNDERTAKER	ADDRESS
A. B. Kephart	2236 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59486 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59486

V

91

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 613 Cornwell st ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miloris Allen

(Residence in Baltimore: No. 613 Cornwell st.

St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colod

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sigle

6-DATE OF BIRTH, Sept (Month) 9 (Day), 1924 (Year)

7-AGE, ...yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Robt Brooks

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Matter Allen

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matter Allen

(Address) 613 Cornell St

15-

Filed ....., 191.....

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

DEC 19 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cold

(Duration) ....yrs. 3 mos. ....ds.

(Signed) M K Goodrich (Coroner) M. D.

12-19..., 1924 (Address) 113 W. Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 20, 1924

20-UNDERTAKER John H. Todrin — ADDRESS 142 W Hill St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59487

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH 605 Truxton St.

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... St.) 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bush

(a) RESIDENCE. No. 605 Truxton St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or — min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rosie Whiteley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Records O.C.S.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

DEC 19 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Dec 17, 1921, that I last saw her alive on Dec 17, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. H. Cuthrell, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec 19 19

20 UNDERTAKER R. C. Gross 1405 McElderry — ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59488

D 59488

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1243 Sargeant St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Gibson

(a) RESIDENCE. NO. 1243 Sargeant. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Leo. J. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Beulah L. Galloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Beulah L. Gibson
(Address) 1243 Sargeant St

15 Filed DEC 19 1921 Robert P. Carlson, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-19-1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1921, to Dec 19, 1921, that I last saw h in alive on Dec 19, 1921, and (that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Dyptheria

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A. Dean, M. D.

(Address) c/o 76 Edmondson Ave.

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Dec 20 1921

20 UNDERTAKER Mr. & Mrs. J. W. Imfeld & Son ADDRESS 611 N. Fremont

D 59489 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59489

CERTIFICATE OF DEATH.

REGISTERED No. C 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 225 Harrison St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Manor

(Residence in Baltimore: No. 225 Harrison St. St.; 3 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	unknown

6-DATE OF BIRTH, ... (Month), 1 (Day) ..... (Year)

7-AGE, about 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Day

9-BIRTHPLACE, (State or Country), Greece

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) .....

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

DEC 19 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon monoxide poisoning — accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Dec 19, 1921. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).—

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	12/20, 1921
20-UNDERTAKER	ADDRESS
Robert Bruhsen	Calhoun

Spec.—1-10-21—M&T—1500 Bks.

D 59490 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59490

X 64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Port St., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Knellinger

(a) RESIDENCE NO. 1605 Port ST., WARD Harford Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of George Knellinger

6 DATE OF BIRTH (month, day, and year) March 6, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER John Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kutzown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Laura Knellinger. (Address) 1605 N. Port St.

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov-13, 1921, to Dec-18th, 1921, that I last saw her alive on Dec-17th, 1921, and that death occurred, on the date stated above, at 430 A m.

The CAUSE OF DEATH* was as follows:

a Paralysis Cerebral apoplexy (duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1605 Port St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C Tom Jones M. D.

, 19 (Address) 2802 Rockyngs

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mountain Christian Church

DATE OF BURIAL 12/20 1921

20 UNDERTAKER Wilkins Corp

ADDRESS Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

EC 1 9 100

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59491

CERTIFICATE OF DEATH.

50 D 59491

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N Stricker ST., 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Reynolds

(a) RESIDENCE NO. 426 N Stricker ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. C. Reynolds.

6 DATE OF BIRTH (month, day, and year) Feb 23, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. C. Reynolds (Address) 426 N. Stricker St.

15 DEC 19 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1921, to December 17, 1921.

that I last saw h-d alive on December 17, 1921

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis.

(Signed) Robert C Mikel, M. D.

Dec 19 1921 (Address) 215 Chilton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 20 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Fremont Av

Burial Permit Clerk.

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Facano) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59492 64 D 59492

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Bank ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Filomena Facano

(a) RESIDENCE NO. 1426 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Domenick Facano

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71 yr.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Emanuel Bulicino

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Bulicino

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Domenick Facano (Address) 1426 Bank St

15 Filed ..... 19..... Registrar

Robert P. Harrison, Burial Permit clerk

DEC 19 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to Dec 17, 1921, that I last saw her alive on Dec 10, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(Cerebral Hemorrhage)

(duration) yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? --- Date of ---

Was there an autopsy? ---

What test confirmed diagnosis?

(Signed) Amos L Entwisle M. D.

Dec 19, 1921 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pancratius Cem

DATE OF BURIAL: Dec 19 1921

20 UNDERTAKER: Wendelschaefer (Sons)

ADDRESS: 8/ Alon

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59493

CERTIFICATE OF DEATH.

91

D 59493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Beach St. Curtis Bay ST.; 25 WARD)

2-FULL NAME John Smolik

(a) RESIDENCE. NO. 9 Beach St. Curtis Bay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Annie Smolik

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040
Car wrker

(b) General nature of industry, business, or establishment in which employed (or employer) Oldg. repairing cars.

(c) Name of employer Balto Car & Foundry Co.

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Vincent Smolik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Rosie Stonkovska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Tenia Schatlik
(Address) 9 Beach St. Curtis Bay

15 Filed Dec 19 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1921, to Dec. 17, 1921, that I last saw him alive on Dec. 16, 1921, and that death occurred, on the date stated above, at 12:15 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) ~~~~

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~~~~

Did an operation precede death? no Date of ~~~~.

Was there an autopsy? no

What test confirmed diagnosis? Clinical only.

(Signed) Geo B Davis, M. D.

3/17, 1924 (Address) 711 Church St. Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross M. E. S. Co

DATE OF BURIAL Dec 20 1921

20 UNDERTAKER Frank Crockett Son

ADDRESS 1906 Eutaw Pl

DEC 19 1921 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59494 — 28 — D 59494

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Mansfeldt ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma A. Williams

(Residence in Baltimore: No. 18 Mansfeldt ave St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Sigle

6-DATE OF BIRTH, Sept. (Month) 6 (Day), 1900 (Year)

7-AGE, 21 yrs. 3 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: June
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. George William

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rosella Barrett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver Williams

(Address) Mt Washington and

15-

Filed Robert P. Harrison, 191

Registrar.

DEC 19 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15 1921, to Dec 18 1921, that I saw h-m alive on Dec 18 1921, and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. A. Becker M. D

12-19, 1921 (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL. , 191
Mt Lebanon Cemetery Baltimore Co. Md.	
20-UNDERTAKER	ADDRESS
E. Roy Steffey	Mt Washington

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59495

CERTIFICATE OF DEATH.

118 D 59495

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Edward P. Gill

(a) RESIDENCE. NO. 4200 Greenway, Guilford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Edward P. Gill

6 DATE OF BIRTH (month, day, and year) July 13th, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. D. Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Isabel Paddington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Dr. N. A. Bakjes. (Address) 4 E. Fredrick

15 Filed DEC 20 1921, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from November 23rd, 19 21, to December 19th, 19 21, that I last saw him alive on December 19th, 19 21, and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of November 23rd

Was there an autopsy? Yes

What test confirmed diagnosis? Operation - Autopsy

(Signed) George E. W. Hardy, M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: 12-21 1921

20 UNDERTAKER: George W. Jenkins Home Co. ADDRESS: McCulloh & Orchard.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation done for a
Supposed Stone in
Common Duct & found
Acut Pancreatitis

Spec. 6-9-19—H. P. Co.—10,0 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59496

CERTIFICATE OF DEATH.

138 D 59496

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Preuak

(a) RESIDENCE. NO. 5101 Elliott ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jos. Preuak

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Jorge Fitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Ch. Kroon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Joseph Preuak
(Address) 3101 Elliott St

15 DEC 20 1921 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/8/, 1921, to 12/18/, 1921, that I last saw her alive on 12/18/, 1921, and that death occurred, on the date stated above, at 12.10 PM

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. Hospital Surgeon Findings

(Signed) H. N. Freeman, M. D.

, 19 (Address) 2631 E Coldspt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 21 1921
20 UNDERTAKER	ADDRESS
Thos. Ewart Sr	1906 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-16—M. & T.—2000 Bks.

D 59497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59497

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Orleans St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Smith

(Residence in Baltimore: No. 1431 Orleans St St.: 20 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, December 25, 1843 (Month) (Day) (Year)

7-AGE, 77 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Smith

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Linda Tarver

(Address) 1431 Orleans St

15- DEC 20 1921 ROBERT R. KRAUTER, Registrar.

Filed....., 191..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1921, to Dec 18 1921, that I saw h in alive on Dec 18 1921, and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchitis Hypostatic

(Duration) 1 yrs. ....mos. ....ds.

(Signed) Richard L. Cosgrove M. D.

Dec 19, 1921. (Address) 1514 Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Christfield	Dec 20, 1921
20-UNDERTAKER John W Henderson	ADDRESS 1502 E Monument St

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 59498

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59498

CERTIFICATE OF DEATH.

REGISTERED NO. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby of Amelia Danielczik

(a) RESIDENCE NO. Colgate, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Julius Danielczik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Amelia Jarrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Johns Hopkins Hospital Hospital

15 Filed DEC 20 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1921, to Dec. 11, 1921, that I last saw him alive on Dec. 11, 1921, and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Intracerebral haemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) ..... M. D.

..... 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner of Health.

per Wm. R. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59499

CERTIFICATE OF DEATH.

D 59499

1-PLACE OF DEATH 432 N. Durham St 6 15 REGISTERED NO.

CITY OF BALTIMORE: (No. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Allen.

(a) RESIDENCE. No. 432 N. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
—	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER William Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Florence Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Johns Hopkins Hospital O.D.S.
(Address)

15 Filed DEC 20 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1921, to Dec. 11, 1921, that I last saw h(e) alive on Dec. 11, 1921, and that death occurred, on the date stated above, at 4:8 m.

The CAUSE OF DEATH* was as follows:

Atelectasis (Congenital)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) W. H. Cuttrell, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL DEC 1 - 1921

Commissioner Health.

Per. Wm. S. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59500

CERTIFICATE OF DEATH.

90 D 59500

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1709 N.Broadway ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Rawlings

(a) RESIDENCE. No. 1709 N.Broadway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George A.Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Almira Woodcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant James M.Rawlings
(Address) 1709 N.Broadway

15 Filed DEC 20 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.18.1921[19]

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1915. to Dec 18. 1921.
that I last saw h alive on Dec 18. 1921.
and that death occurred, on the date stated above, at 5.30 P m.
The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? following Pleurisy

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Bryon M. D.

Dec 19 1921 (Address) 1107 Lexington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt.Olivet Cemetery	12-20-21[19]
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59501

CERTIFICATE OF DEATH.

D 59501

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 N Monsford ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stockman

(a) RESIDENCE NO. 1721 N Monsford ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE~~ of Mary Elizabeth Linn Stockman

6 DATE OF BIRTH (month, day, and year) Sept. 13-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36.	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer) N.K. Boggs

(c) Name of employer Con Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Charles Stockman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary Elizabeth Stockman
(Address) 1721 N Monsford.

15 Filed DEC 20 1921 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1921, to Dec. 18, 1921, that I last saw him alive on Dec 17, 1921, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis
(duration) yrs. 4 mos 18 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no.

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Thos Fa Stevens, M. D.

12/18 1921 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec 21st 1921
UNDERTAKER John J. Cowan Son	ADDRESS
per F.J. Cowan	701 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59502

CERTIFICATE OF DEATH.

120 D 59502

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Tyson ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert W. Ballard

(Residence in Baltimore: No. 704 Tyson St.; 20 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Married

6-DATE OF BIRTH, Sept (Month) ..... (Day), 1871 (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Dk

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Ballard

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Caroline Winder

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Magdalena Ballard Per C.J.K.

(Address) 704 Tyson

15- Filed DEC 20 1921, 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1921, to Dec 17th 1921, that I saw h[er] alive on Dec 16 1921, and that death occurred, on the date stated above, at 5th a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis and Valvular Heart Disease Mitral incomp. (Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) None known (Duration) yrs. mos. ds.

(Signed) Chas. J. Kelly M. D.

....., 191... (Address) 324 W. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Dec 20 1921
20-UNDERTAKER Daniel Easton	ADDRESS 916 Park

MARGIN RESERVED FOR BINDING

...B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59503

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Caplin or Mary E. Ware

(a) RESIDENCE. No. ~~Unknown~~ 751 George ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	~~Unknown~~ Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1853 Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Unknown~~ None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): ~~Unknown~~ Frederick Md

PARENTS

10 NAME OF FATHER: Abraham Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Unknown~~ Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed DEC 20 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from December 15, 1921, to December 16 1921.

that I last saw her alive on December 16, 1921,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Daniels, M. D.

12/17/1921 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: Dec 20 21

20 UNDERTAKER: Samuel Hensley ADDRESS: 578 W Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

Fred - 2 Bryant Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59504

CERTIFICATE OF DEATH.

64 D 59504

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Norwood Ave (St.) 25 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvira G McDonnell

(a) RESIDENCE. No. Norwood Ave St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas McDonnell

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city ~~or town~~) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel O Love

11 BIRTHPLACE OF FATHER (city ~~or town~~) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Georganna Knight

13 BIRTHPLACE OF MOTHER (city ~~or town~~) (State or country) Baltimore Md

14 Informant Thomas McDonnell

(Address) Norwood Ave

15 Filed DEC 20 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 11 . 1921 . to Dec. 18 . 1921 .

that I last saw her alive on Dec. 18 . 1921 .

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema 7

(duration) yrs. mos. 1 d.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J Henry J Faber, M.D.

, 19 (Address) 3317 Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 21 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North Ave

MARGIN RESERVED FOR INDEXING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59505

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59505

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S. Chapel ST.: 2 WARD)

2-FULL NAME Henry A. Mills.

(a) RESIDENCE. No. 503 S. Chapel ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Mills.

6 DATE OF BIRTH (month, day, and year) April 5th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	12	

8 OCCUPATION OF DECEASED 66V

(a) Trade, profession or particular kind of work Waterman at

(b) General nature of industry, business, or establishment in which employed (or employer) Spedden's Ship yard.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Henry A. Mills.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Mary A. Mills
(Address) 503 S. Chapel St.

15 Filed DEC 20 1921 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 23 1921, to Dec 17 1921.

that I last saw him alive on Dec 17 1921,

and that death occurred, on the date stated above, at 11.00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. L. Neer, M. D.

, 19 (Address) 408 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Dec 20th 1921
20 UNDERTAKER Lilly Zeiler	ADDRESS 400 S. Wolfe

...AINLY, WITH UN... ...should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be pro... TION is very important. See instructions on back of cert...

D FOR BINDING

PERMANENT RECORD. Every item ... EXACT ... PHYSICIANS ... U.P.A.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59506

CERTIFICATE OF DEATH.

N 172

D 59506

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mc-onald

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rhode Island

PARENTS

10 NAME OF FATHER Alexander McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kitty O'Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed DEC 20 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 19 21

17

I HEREBY CERTIFY, That I attended deceased from November 25, 19 21, to December 18, 19 21, that I last saw him alive on December 17, 19 21, and that death occurred, on the date stated above, at 6:00 A. M. m.

The CAUSE OF DEATH* was as follows:

Fractured Hip - right (over)

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Bronchs - Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Brady M. D.

12/18/21 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Dec 20 1921
20 UNDERTAKER Lilly & Zirkin	ADDRESS 403 N. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certific

MARGIN RESERVED FOR

Spec. — 6-9-19—H. B. Co.— 1000 Bks.

D 59507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 59507

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Dorsey

(a) RESIDENCE. No. Unknown St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 940

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed , 19 Registrar

DEC 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from February 5, 1921, to December 16, 1921, that I last saw him alive on December 16, 1921, and that death occurred, on the date stated above, at 10:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Mitchell, M. D.

12/16/19 21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Dec 19 1921
20 UNDERTAKER	ADDRESS
Edw. Ruggold	1463 Carey

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 59508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1V 59508

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Fremont & half ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Carter

(Residence in Baltimore: No. 304 - 20½ St.; 9 yrs., 4 mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single.

6-DATE OF BIRTH, August 18, 1912
(Month) (Day) (Year)

7-AGE, 9 yrs. 4 mos. ~ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), born in Baltimore Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jno. W. Carter.

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Mary Banks.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John. W. Carter

(Address) 304 20½ St Baltimore

15-

Filed DEC 20 1921, 19..

H Wehn Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 18, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 16 1921, to Dec. 18, 1921, that I saw her alive on Dec. 18, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

called to see her ofen

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY Same

(Secondary)

was attended by physician from Dec 9, 1921

(Duration) ....yrs. ....mos. ....ds.

(Signed) Hugh Forsythe, M. D.

Dec 19..., 1921 (Address) 424 E North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Gloster Co Va

DATE OF BURIAL, Dec. 20..., 1921

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Oakland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59509 — 120 — D 59509

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Linden

(a) RESIDENCE. No. 212 Appleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Ernest Linden

6 DATE OF BIRTH (month, day, and year) Mar 22-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Pierre Jevalloiz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eugene Linden
(Address) 912 N. Appleton St

15 DEC 20 1921 ROBERT R. KRAETER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1921, to Dec 19, 1921, that I last saw h.er alive on Dec 19, 1921, and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis ?
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac failure
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia, Blood Urea

(Signed) J. Stanley Gabill, M. D.

, 19 (Address) 2844 Clifton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 21 19
20 UNDERTAKER	**ADDRESS**
Jos. Weber & Son	2503 Edmondson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59510

CERTIFICATE OF DEATH.

151 D 59510

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3131 Mc Elderry St.; 7 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Neubert

(Residence in Baltimore: No. 3131 Mc Elderry St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Dec (Month) 19 (Day), 1921 (Year)

7-AGE. ..yrs..mos..ds. If LESS than 1 day, 7 hrs. or 30 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). 00

9-BIRTHPLACE. (State or Country). Balto.

PARENTS.

10-NAME OF FATHER. John A. Neubert

11-BIRTHPLACE OF FATHER (State or Country). Balto.

12-MAIDEN NAME OF MOTHER Grace M Ellis

13-BIRTHPLACE OF MOTHER (State or Country). Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). John A. Neubert

(Address) 3131 Mc Elderry

15- Filed DEC 20 1921, 191.. ROBERT R. KRAUTER, Registrar. Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1921, to Dec 20 1921, that I saw h.. alive on Dec 19 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

Fell & Broke Neck

(Duration) ..yrs. 7 mos. ..ds.

CONTRIBUTORY (Secondary)

(Duration) ..yrs. ..mos. ..ds.

(Signed) C. C. Deacon M. D.

1720 E. Balto St. (Address)

Dec 20, 1921.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL. Dec 20, 1921

20-UNDERTAKER Geo. W. Smith & Son

ADDRESS 811 Washington

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59511

CERTIFICATE OF DEATH.

D 59511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Gen. Hospital ST., 4 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Hollins

(a) RESIDENCE NO. 86 Prince George St. Annapolis Md ST., WARD Annapolis Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary E. Hollins

6 DATE OF BIRTH (month, day, and year) June 25th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs Emma Ackerman
(Address) 1272 James St

15 Filed DEC 20 1921 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1921, to Dec 19, 1921,

that I last saw him alive on Dec 19, 1921,

and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

~~Same~~

Cancer of stomach (pylorus)

(Duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Surgical Shock

(duration) yrs. mos. 12hrs ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 12/19/21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Pokorny, M. D.

, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 12-23 1921

20 UNDERTAKER E & R Stark — ADDRESS 115 E Mulberry

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59512

CERTIFICATE OF DEATH.

28 D 59512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3135 W. North ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Francis F. Palm

(a) RESIDENCE No. 3136 W North Ave. WARD 16

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida V. Palm

6 DATE OF BIRTH (month, day, and year): Jan 6, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	34	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman Marine Dept

(b) General nature of industry, business, or establishment in which employed (or employer): Hardware

(c) Name of employer: Wm. H. Whiting & Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank F. Palm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Caroline H. Scholle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Ida V. Palm

(Address): 3135 W. North Ave

15 Filed DEC 20 1921 ROBERT R. KRAMER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1921, to Dec 19, 1921.

that I last saw him alive on Dec 19, 1921.

and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Duration (duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mns. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None needed

(Signed) Chas. S. Tarr M. D.

, 19 (Address) 3123 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine — DATE OF BURIAL: Dec 21 19

20 UNDERTAKER: Fickler & Fickler E.J.F. — ADDRESS: Cazenovia 1639

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59513

CERTIFICATE OF DEATH.

120 D 59513

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 708 N. Monroe St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almira Cornelia Fredrick

(Residence in Baltimore: No. 708 N. Monroe St.; 8 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Married

6-DATE OF BIRTH, June (Month) 5 (Day) 1849 (Year)

7-AGE, 72 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, David Travis

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Elizabeth Skipper

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Fredrick

(Address) 1075 N. Fulton Ave

15-

Filed DEC 20 1921 191.... G. J. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 17 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1921, to Dec 17 1921, that I saw her alive on Dec 17 1921, and that death occurred, on the date stated above, at 10.05 m.

The CAUSE OF DEATH* was as follows:

1. Acute Dilatation of Stomach

(Duration) yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Pneumonia

(Duration) yrs. abt 15 mos. — ds.

(Signed) Robt. E. Tolson M. D.

Dec 19, 1921. (Address) 1318 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Dec 20, 1921
20-UNDERTAKER Joseph B Cook	ADDRESS 1103 N Balto St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks Chr. Interstitial Nephritis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59514

CERTIFICATE OF DEATH.

79 D 59514

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2713 Reese ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Murphy

(a) RESIDENCE NO. 2713 Reese ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph F. Murphy

6 DATE OF BIRTH (month, day, and year) Sept 7-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Geo. W. Trundo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Spellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Ella Scriven

(Address) 2713 Reese St

15 Filed DEC 20 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/1/21, 19, to 12/14/21, 19, that I last saw her alive on 12/14/21, 19, and that death occurred, on the date stated above, at 11:40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? ✓

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Greenwaudes, M. D.

12/24/21, 19 (Address) 521 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 12/22, 1921

20 UNDERTAKER: Chas F. Coane & Son — ADDRESS: 118 W Mt Royal ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59515 150 D 59515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Register ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Keller

(a) RESIDENCE. No. 1718 Register ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Harry Keller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Steelberg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Harry Keller
(Address) 1718 Register St

15 Filed 19 Robert P. Harrison, Registrar

DEC 20 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1921, to Dec 18, 1921, that I last saw h— alive on Dec 18, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J Cirey, M. D.

, 19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Dec 21 1921
20 UNDERTAKER	ADDRESS
W.M. Cook.	501 E. North

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59516

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S. Smallwood ST.: 20 WARD)

2-FULL NAME. William W. L Adams

(a) RESIDENCE. NO. 305 S. Smallwood ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 22. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	.	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Ida Wohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Frank Adams 305 S. Smallwood

15 Filed DEC 20 1921 19 ROBERT P. MERRICK, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 19. 1921. to Dec 19. 1921. that I last saw alive on Dec 19. 1921. and that death occurred, on the date stated above, at 5.30A m.

The CAUSE OF DEATH* was as follows:

Interstitial Hemorrhage, Cerebellum

(duration) yrs. mos. 2 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) W. W. Dawson, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Dec: 21 1921

20 UNDERTAKER C. W. Dill ADDRESS 3109 Fredk. Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59517

CERTIFICATE OF DEATH.

109 D 59517

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.; No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E. Parker

(a) RESIDENCE. NO. 7 S. Hilton ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Elias H. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Lizzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed Robert P. Harrison, 19
Registrar
Burial Permit Clerk.

DEC 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 1921, to Dec. 19, 1921, that I last saw h[illegible] alive on Dec. 19, 1921, and that death occurred, on the date stated above, at 3:15 P.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Operation Shock

(duration) 1 hour mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? Yes. Date of Dec 19 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. [illegible] Bradley, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Post Oak — DATE OF BURIAL: Dec 21 1921

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1510 W[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59518 D 59518

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 637-West North Ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Lake Harrison

(a) RESIDENCE. No. 637-West North Ave. ST., 14 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 66 yrs. 3 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward G. Harrison.

6 DATE OF BIRTH (month, day, and year) Sept-11-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pennsylvania

PARENTS

10 NAME OF FATHER Samuel S. Warthman

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Emily A. Langer

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Pennsylvania

14 Informant Mrs. Honora P. Kantner (daughter in-law)
(Address) 637-West North Av., City.

15 Filed Dec 20 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to Dec 19 1921
that I last saw h alive on Dec 19 1921
and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis with Uremia
Terminal Bronchopneumonia.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart & Kidneys Exam

(Signed) David Edgington, M. D.

Dec 20 1921 (Address) 637 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Dec-21-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

D 59519 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59519

CERTIFICATE OF DEATH.

1 PLACE OF DEATH Schooner Helen M. Baughman, REGISTERED NO. C

CITY OF BALTIMORE (No. York & William Sts. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Herbert Scott. (C)

(Residence in Baltimore: No. Shadyside, A. A. Co. Md. St., yrs., mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Single.

6-DATE OF BIRTH, December 11th. 1888, 1
(Month) (Day) (Year)

7-AGE. 33 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Deckhand.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Shadyside, A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, John Boone. (C)

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Rachael Scott. (C)

13-BIRTHPLACE OF MOTHER (State or Country). Shadyside, A. A. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Crowner. (C) sister

(Address) Shadyside A. A. Co. Md.

15- Robert P. Harrison,

Filed....., 191.....

Burial Permit Clerk. Registrar.

DEC 20 1921

N.B.—Every item of information should be carefully supplied. AGE must be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19th. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, au
inquiry found that said deceased came to his death
topsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. M. Reinhardt M. D.
(Coroner)

Dec 20th 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence Shadyside, A. A. co. Md.

19-PLACE OF BURIAL OR REMOVAL, Shadyside Cem. DATE OF BURIAL, Dec. 21, 19.21

20-UNDERTAKER Jones & Jones, ADDRESS 313 Gunpowder

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59520 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 59520

170

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1290 Riverside Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Aro

(a) RESIDENCE. NO. 1290 Riverside Ave ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a [redacted], widowed, [redacted] (or) WIFE of Lewis Aro

6 DATE OF BIRTH (month, day, and year) Mar 17 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chris Rosenbrock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ann Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant James A Pyatt
(Address) 1290 Riverside Ave

15 Filed Robert F. Harrison, Registrar

C 20 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-18 1921

17 I HEREBY CERTIFY, That I attended deceased from — , 1915, to 12/18 , 1921, that I last saw h[redacted] alive on 12-18 , 1921, and that death occurred, on the date stated above, at 7- P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Chemical analysis.

(Signed) Philip S. Tauber, M. D.

12/20, 1921 (Address) 432 Williams St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	12/21/21 19
20 UNDERTAKER John J Fahey & sons 1518 Light st	ADDRESS

C. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. Exact statement of information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59521

CERTIFICATE OF DEATH.

109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1452 Wiconisco ST.) (21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Arold

(a) RESIDENCE. No. 1452 Wiconisco ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 1 1872

7 AGE: Years 49 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): M. W. & V. Line

(c) Name of employer: Md. & Del. Line Steamboat Co.

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Arold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Theresa Arold 1452 Wiconisco

Filed DEC 21 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-19 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 19, 1921, that I last saw h— alive on Dec 19, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Post operative)

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) adhesions (abdominal)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Dixon, M. D.

, 19 (Address) 1752 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Dec 22 1921

20 UNDERTAKER: Elmer W. Carkhuff

ADDRESS 924 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in years, months and days if under one year, and the exact age at last birthday should be given in all cases where it can be obtained. Exact statement of information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59522

CERTIFICATE OF DEATH.

80 D 59522

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Simon

(a) RESIDENCE NO. 1622 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Rosenthal Simon

6 DATE OF BIRTH (month, day, and year) Jany 3-5 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Orleans

PARENTS

10 NAME OF FATHER Lazare Simon

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Orleans

12 MAIDEN NAME OF MOTHER Caroline Selkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Simon

(Address) 1622 Linden Ave

15 Filed DEC 21 1921 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/21 19

17

I HEREBY CERTIFY, That I attended deceased from 12/10/21 19 2.30 P.M. 12/10/21 19 5.30 P.M.

that I last saw h/s alive on 12/10/21 19

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ezekiel Hirsberg M. D.

12/11, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew — DATE OF BURIAL Dec 21st 19 21

20 UNDERTAKER Edward Goodman — ADDRESS 1840 Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of all information should be carefully supplied. AGE should be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59523

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 59523

CERTIFICATE OF DEATH.

170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4321 Garrison Ave ST.: 28 WARD)

2-FULL NAME Mary Essig

(a) RESIDENCE. No. 4321 Garrison Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of William Essig

6 DATE OF BIRTH (month, day, and year) Sept 12th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christine E Balsiano
(Address) 4321 Garrison Boulevard

15 Filed DEC 21 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 19 1921, that I last saw h alive on Dec 19 1921, and that death occurred, on the date stated above, at 3.05 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

CONTRIBUTORY (Secondary) Chr. Int. Nephritis (duration) yrs. mos. 10 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital—no.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. L. Wenzke M. D.

12/20, 1924 (Address) 1302 N Loudon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 22nd 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

N. B.—WRITE PLAINLY. WITH INK. All items should be properly supplied. AGE should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59524

CERTIFICATE OF DEATH.

64 D 59524
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 936 N Gay St. ST. 22 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Shofer
(Residence in Baltimore: No. 626 Watson St.) St. 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1864 (Year)

7-AGE, 57 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Toy Store

9-BIRTHPLACE, (State or Country) Russia

PARENTS.
10-NAME OF FATHER. Saul Asoor
11-BIRTHPLACE OF FATHER (State or Country) Russia
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Shofer
(Address) 931 N. Gay St.

15- DEC 21 1921 Filed 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Apoplexy.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. Kurt Steiner M. D. (Coroner)
12 21, 1921. (Address) 4 E. Lex. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount DATE OF BURIAL, DEC 21, 1921
20-UNDERTAKER Geo. Lewis, ADDRESS 1411 E. Pratt

N. B.—Every item of information should be carefully supplied. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59525

54

D 59525

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathew Doyle

(a) RESIDENCE. NO. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pedler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)... Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed DEC 21 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from November 25. 1921, to December 19, 1921, that I last saw him alive on December 18, 1921, and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(duration) 1 (yrs.) mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes Blood

What test confirmed diagnosis?

(Signed) Clifford O'Neill, M. D.

12/19/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Hospital Rd DATE OF BURIAL 12/21 1921

20 UNDERTAKER William Cook ADDRESS 502 E Nash

N. B.—WRITE PLAINLY. All items must be supplied. AGE should be properly classified. Exact information should be carefully supplied, so that it may be properly classified. Exact information should be carefully supplied. AGE

D 59526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59526

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1748 Carroll st. ST. 13 WARD)

2-FULL NAME Margaret Bruggemann.

(Residence in Baltimore: No. 1748 Carroll st

St.; 48 yrs., 4 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) married

6-DATE OF BIRTH, July 21, 1873 (Month) (Day) (Year)

7-AGE, 48 yrs. 4 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER M. Pund.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. H. Bruggemann

(Address) 1735 Carroll

15-

Filed DEC 21 1921 191.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) .....yrs.....mos. 1/2 hr. ds.

CONTRIBUTORY (Secondary) and history

(Duration) .....yrs.....mos.....ds.

(Signed) J. J. Hennessy M. D. (Coroner)

Dec. 20 1921, (Address) 1522 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. In the of death .....yrs.....mos. 1 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Eastern Avenue & Ann St. Cor. Md. Gen. Hosp.

Former or usual residence 1748 Carroll St.

19-PLACE OF BURIAL OR REMOVAL, Baltimore County.

DATE OF BURIAL Dec 21, 1921

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford Ave

N. B.—Every item of information should be carefully supplied. All the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64

D 59527 REGISTERED NO. D 59527

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3108 Clifton Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Pearson Sanderson Williams

(Residence in Baltimore: No. 3108 Clifton Ave St.; all life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: April (Month) 16 (Day), 1840 (Year)

7 AGE: 81 yrs. 8 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): (00)

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thomas Sanderson

11 BIRTHPLACE OF FATHER (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Hannah A. Pearson

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia H Eichelberger

(Address) 1600 Hilton St

15 [illegible]

Filed DEC 21 1921, 191 ROBERT R. KRAUTER, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 20 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 5" 1921 to Dec 20" 1921, that I saw her alive on Dec 20" 1921, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebs Hemorrhage and Left Paralysis

(Duration) yrs. 2 mos. 15 ds

Contributory (SECONDARY) Cardiac Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Herbert E. Lehr M. D.

Dec 21, 1921 (Address) 3210 Hackwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Frederick Md. DATE OF BURIAL: Dec. 22 1921

20 UNDERTAKER: John Mitchell ADDRESS: 1301 W. Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated [illegible] WRITE PLAINLY. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59528 — 120 D 59528

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 N. Patterson Park Ave. WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Garrison

(a) RESIDENCE NO. 735 N. Patterson Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm. T. Garrison

6 DATE OF BIRTH (month, day, and year) March 9. 1861

7 AGE — Years: 60 — Months: 9 — Days: 11 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Silas De Vaughn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza House

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) William T. Garrison 735 N. Patterson Park Ave

15 Filed DEC 21 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 19 21, to Dec 20, 19 21, that I last saw her alive on Dec 19, 19 21, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Diffuse Nephritis

(duration) yrs. 1 mos 25 ds.

CONTRIBUTORY (Secondary) Ex Lumbago (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine analysis

(Signed) Adolph E. Deimler M. D.

Dec 21, 1921 (Address) 2201 Greens Ln.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Dec 23 1921

20 UNDERTAKER: A. Sander & Sons — ADDRESS: 1710 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of AGE should be carefully supplied. Exact statements, so that it may be properly classified. Exact statement should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Sienkielewski)

D 59529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 V D 59529

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 508 S Broadway ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Sienkielewski

(a) RESIDENCE NO. 508 S Broadway ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19 1721

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 00

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Sienkielewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Barbara Swarcowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czecho Slovakia

14 Informant (Address) Joseph Sienkielewski 508 S Broadway

15 Filed DEC 27 1921, 19.... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in every case. Exact statistical information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statistical information should be carefully supplied, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-14 1924 to 12-21 1924 that I last saw him live on 12-20 1924 and that death occurred, on the date stated above, at 4 A, m.

The CAUSE OF DEATH* was as follows:

Difficult child Birth.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos 2 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

12-21 1924 (Address) 508 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross German Hill Road	Dec 24 1924

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59530

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: NO. 1391 Woodyear ST.: 15 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Brown

(a) RESIDENCE. NO. 1391 Woodyear ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) Uncertain.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver 023
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer unknown Howard Co. Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Brown
11 BIRTHPLACE OF FATHER (city or town) St Mary's (State or country) Md
12 MAIDEN NAME OF MOTHER Mary Smith
13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Fannie Jones (Sister)
(Address) 2428 N. Royal Terrace

15 Filed DEC 21 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1921, to Dec 20, 1921, that I last saw h— alive on Dec 19, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis
(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physician.

(Signed) F. C. Link M. D
Dec 20 1921 (Address) 1318 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Laurel de Grand O. — Dec 23 1921

20 UNDERTAKER — ADDRESS
Geo. A. Lewis — Laurel

N. B.—WRITE PLAINLY, WITH UNFADING INK. All the items stated EXACTLY as they should be stated. Exact statement of AGE should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

D 59531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59531

CERTIFICATE OF DEATH.

175-001

REGISTERED NO. C

1-PLACE OF DEATH Broadway & Pratt St

CITY OF BALTIMORE (No. ~~809 S Pat~~ St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Kolacki

(Residence in Baltimore: No. 809 S Pat St St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 19 (Day), 1858 (Year)

7-AGE, 63 yrs. 6 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE. (State or Country), Poland

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (State or Country). Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Mackowiak

(Address) 111 Carmel Road

15-

Filed ....., 191.....

DEC 21 1921 ROBERT B. KRAUTER, Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Investigation find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Crushed & Killed by Train at Broadway & Pratt St (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Gray M. D. (Coroner.)

Dec 21, 1921 (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem

DATE OF BURIAL, Dec 23, 1921

20-UNDERTAKER Stephen Kotkowski

ADDRESS 1000 Kenwood Ave

N. B.—Every item of information should be carefully supplied. Blanks may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59532

D 59532

CERTIFICATE OF DEATH.

REGISTERED NO. C 9104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Abbotson Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula S. Potter

(Residence in Baltimore: No. 1718 Abbotson Av St.; ....yrs., 6 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 29, 1921.
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 23 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: home girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), U. S. A. Balto Md

PARENTS.

10-NAME OF FATHER, James L Potter

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Realm Gebbs

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L Potter

(Address) 1718 Abbottston Av

15- ROBERT R. KRAUTER,

Filed DEC 21 1921 191.... Burial Permit Clerk.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1921, to Dec 21 1921, that I saw h[illegible] alive on Dec 20 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jacob Fischer M. D.

Dec 21 1921. (Address) 1823 N Wash Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Altoona Pa.

DATE OF BURIAL, Dec 23 1921.

20-UNDERTAKER H M Rowton

ADDRESS 2238 N North

N. B.—Every item of information should be carefully supplied. Exact statement of occupation may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59533 ✓

D 59533 CERTIFICATE OF DEATH. 45

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. Municipal Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Kahrhof

(a) RESIDENCE. NO. 1032 Hillen St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joe Kahrhof

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed DEC 21 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1921

17

I HEREBY CERTIFY, That I attended deceased from November 30, 1921, to December 18, 1921, that I last saw him alive on December 18, 1921, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Mixed Tumor of Parotid

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ——

Was there an autopsy? ——

What test confirmed diagnosis? ——

(Signed) L. W. Brady M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. per Wm. E. Woodall

ADDRESS

N. B.—WRITE PLAINLY. All information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59534

CERTIFICATE OF DEATH.

D 59534

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Smith

(a) RESIDENCE. No. 1202 Brevard st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Robert Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Dennison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Records

(Address) M.T.H.

15 Filed DEC 21 1921 18763 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1921, to Dec. 19, 1921, that I last saw him alive on Dec. 18, 1921, and that death occurred, on the date stated above, at 4.25 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?* T.B. in sputum, X-ray

(Signed) Francis L. Delafield, M. D.

12-19-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL ROBERT R. KRAUTER, Commissioner of Health. DEC 21 1921 Clerk.

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. See instructions on back of certificates

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37,091

D 59535

D 59535

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stanford

(a) RESIDENCE. NO. 134 East St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charleston, South Carolina

PARENTS

10 NAME OF FATHER: Frank Stanford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charleston, S. Carolina.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charleston, S. Carolina

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed DEC 21 1921 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 17 1921

17

I HEREBY CERTIFY, That I attended deceased from November 16, 1921, to December 17, 1921, that I last saw him alive on December 17, 1921, and that death occurred, on the date stated above, at 10:00 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 32 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? N. K.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. T. Brooks, M. D.

12/19/21 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of mation should be carefully supplied. AGE should be stated in full. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

D 59536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59536

CERTIFICATE OF DEATH.

167

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Ag. Hospital ST.: 25 WARD)

2-FULL NAME Robert E.S-Tucker

(Residence in Baltimore: No. Wilhelm Park,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 19 (Day), 1919 (Year)

7-AGE. 2 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Carroll L. Tucker

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Marie L. Bees

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carroll L. Tucker

(Address) Wilhelm Park

15- Filed DEC 21 1921 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Burns

Accidental

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) H. C. Radcliffe M. D.
(Coroner.)

Dec 21, 1921 (Address) 413 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Dec 22nd, 1921
20-UNDERTAKER	ADDRESS
E Schlosman Son	1034 Hanover St.

N. B.—Every item of information should be carefully supplied. AGE should be stated... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION... important. See instructions on back of certificate.

WRITE PLAINLY

plague around stove

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59537

81 D 59537

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1114 Homewood Ave (ST.) 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia T. Sindall

(a) RESIDENCE. NO. 1114 Homewood Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Sindall

6 DATE OF BIRTH (month, day, and year) Feb 16-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) American

14 Informant Ann Sindall (Address) 1114 Homewood Ave

15 Filed DEC 21 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/21

17 I HEREBY CERTIFY, That I attended deceased from 8/29/21 to 12/19/21

that I last saw her alive on 12/19/21

and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

arteriosclerosis

(duration) 2-3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs (duration) 8 yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Lewis M. D.

12/20, 1921 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Grave	12/22/21

20 UNDERTAKER ADDRESS

H. C. Winfield 914 Gilmor

ROBERT B. KRAUTER, Clerk of the Circuit Court

N. B.—WRITE PLAINLY. WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage. Not tubercular? No further history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59538 9-091 D 59538

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 14 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Linic

(a) RESIDENCE. No. 514 McMechen ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 2yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Laurence Linic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary McCahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant JOHNS HOPKINS HOSPITAL. Records
(Address)

15 Filed DEC 21 1921 Robert P. Harrison. Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-19 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-15, 1921, to 12-19, 1921, that I last saw h[illegible] alive on 12-19, 1921, and that death occurred, on the date stated above, at 10.40 p m.

The CAUSE OF DEATH* was as follows:

Diphtheria - nasal. pharyngeal, laryngeal - (Intubated)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Cultures & Frankel signs

(Signed) Horace G. Stewart, M. D.

Dec. 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Arlington Cem.	Dec 22 1921
20 UNDERTAKER	ADDRESS
Thos J. G. Locke	1302 Jefferson

N. B.—WRITE PLAINLY, WITH LINK. AGE should be stated EXACTLY. Exact statement of AGE should be carefully supplied. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59539 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59539

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 700 N. Carrollton ave. WARD) 16

2-FULL NAME Mary Saudo Turner

(a) RESIDENCE NO. 706 N. Carrollton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard M. Turner

6 DATE OF BIRTH (month, day, and year): Apr. 27-1845

7 AGE: Years 76 — Months — Days 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co. Md.

PARENTS

10 NAME OF FATHER: Dr Wm Saudo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Mary Cross Stuart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co Md

14 Informant (Address): Mrs Helen Saudo 2 Harding Rd.

15 Filed DEC 21 1921 [illegible] Registrar John O. Mitchell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1921, to Dec 20th, 1921, that I last saw her alive on Dec 20th, 1921, and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Bullard M.D.

Dec 21, 1921 (Address) 706 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 22 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE that it may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59540

CERTIFICATE OF DEATH.

64

D 59540

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1937 E. Lafayette Ave ST., 8 WARD)

2-FULL NAME Martha Stambaugh

(a) RESIDENCE NO. 1937 E. Lafayette Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob H Stambaugh

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Manchester
(State or country) Ohio

PARENTS

10 NAME OF FATHER Anderson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Sheehan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant John Stambaugh
(Address) 1937 E. Lafayette Ave.

15 Filed ..... 19.. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Dec 21, 1921, that I last saw him alive on Dec 20, 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob Fisher, M. D.

Dec 21, 1921 (Address) 1823 N. East Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alliance, Ohio. DATE OF BURIAL Dec 21 1921

20 UNDERTAKER C. D. Fanning & Son ADDRESS 1938 E. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated [illegible]. Exact statement of date of birth and age should be carefully supplied. AGE should be properly classified. It may be [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of date of birth and age should be carefully supplied. AGE should be properly classified. It

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59541

CERTIFICATE OF DEATH.

X 91 D 59541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent Asylum WARD)

2-FULL NAME Dora Lee Clark

(a) RESIDENCE NO. St Vincent Asylum WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St Vincent Asylum
(Address) 1401 Dennison

15 Filed . 19 Robert P. Harrison, Registrar

DEC 21 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Dec 18, 1921, that I last saw h[illegible] alive on Dec 18, 1921, and that death occurred, on the date stated above, at 3 45 P.M.

The CAUSE OF DEATH* was as follows: OVER

Bronchus Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (secondary) Acute Cardiac Dilitation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Elias Poblaylo M. D.

Dec 18, 1921 (Address) 1501 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec 21 1921
20 UNDERTAKER	ADDRESS
Martin Hankey & Son	637 W North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of DECEASED'S age, in years, months and days, should be carefully supplied. AGE should be carefully supplied. Exact statement of DECEASED'S age, in years, months and days, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASED'S age, in years, months and days, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

In Balto. about 3 or 4 months. Came from Cumberland. no infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59542

D 59542

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 926 W. Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roma Jen Byrnes.

(a) RESIDENCE. No. 926 W Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 9 - 1921

7 AGE — Years: — Months: 1 Days: 12. If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Walter F Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Pearl Dodgl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Pearl Dodge
(Address): 926 W Chester.

15 Filed , 19 Robert P. Harrison, Registrar

DEC 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1921, to Dec 21, 1921, that I last saw h[illegible] alive on Dec 21, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Immature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm S Sage, M. D.

, 19 (Address) 757 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: Dec 22 1921

20 UNDERTAKER: Mrs C Muller

ADDRESS: 2334 Jeff

N. B.—WRITE PLAINLY, WITH [illegible] ... mation should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Premature birth.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59543

X 138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha L. Carver

(a) RESIDENCE. NO. Pikesville Md ST., WARD. Pikesville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm N Carver

6 DATE OF BIRTH (month, day, and year): Nov. 15, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Robt H Merrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Lehlining

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm N. Carver

(Address) Pikesville Md

15 DEC 21 1921, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/21/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1921, to Dec 21, 1921, that I last saw h[illegible] alive on Dec 21, 1921, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart

Over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Embolus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-7-21

Was there an autopsy? ~~Yes~~ No

What test confirmed diagnosis? C. of Symptoms.

(Signed) Hugh Brent, M. D.

19 (Address) 16 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Dec 23 1921
20 UNDERTAKER: Wm J Pickrel & Sons	ADDRESS: North Ave

DEC 21 1921

Registrar

REGISTRAR.—WRITE PLAINLY, WITH PEN AND INK. ALL ITEMS should be stated EXACTLY. THIS INFORMATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Abt 8 mos pregnant
Ante partum eclampsia
Operation for eclampsia

D 59544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Canton 64D 59544

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Patterson Park Ave 1915 ST.; 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas Doyle

(Residence in Baltimore: No. 452 N Central Ave St.; yrs., 52 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) (Day) 1870 (Year)

7-AGE: 51 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shucker
(b) General nature of industry, business, or establishment in which employed (or employer): Oyster

9-BIRTHPLACE (State or Country): Va

PARENTS.

10-NAME OF FATHER: Jno Doyle

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Emma

13-BIRTHPLACE OF MOTHER (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Thos Doyle

(Address) Baltimore Md

15-

Filed DEC 22 1921, 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Lyon M. D. (Coroner)

Dec 21 1921 (Address) 1800 E Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Dec 22 1921

20-UNDERTAKER: Milton Davis — ADDRESS: 315 N Eden St

N. B.—Every item of information should be carefully supplied. AGE, if only approximate, should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59545 — 64 D 59545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Rosedale St ST.: 16th WARD)

2-FULL NAME Charles Edward Markland

(a) RESIDENCE. No. 1502 Rosedale ST., 16th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Markland

6 DATE OF BIRTH (month, day, and year) May 29, 1846

7 AGE 75 Years 7 Months 9 Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED 050

(a) Trade, profession or particular kind of work Retired painter

(b) General nature of Industry, business, or establishment in which employed (or employer) Not employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md.

PARENTS

10 NAME OF FATHER John T. Markland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co Md.

12 MAIDEN NAME OF MOTHER Elizabeth Downes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Willard Carlton Markland
(Address) 1502 Rosedale st

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14th, 1921, to Dec 20th, 1921, that I last saw him alive on Dec 20th, 1921, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Generalized arteriosclerosis Chronic Bright's Disease

(duration) 20 yrs. — mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Clinical symptoms

(Signed) W. Edgar Fay, M. D.

, 19 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec 22 1921

20 UNDERTAKER George D. Smith ADDRESS Fayette St

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied

Spec.—8-9-19—H. P. Co.—1000 Bks.

D 59546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59546

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Wells

(a) RESIDENCE. NO. 2241 Barclay st. ST., WARD,

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sara Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed DEC 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1921, to Dec. 20, 1921, that I last saw him alive on Dec. 19, 1921, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pneumothorax

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dedaplane, M. D.

12-20-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Long Green Md. DATE OF BURIAL: Dec 22 19 21

20 UNDERTAKER Samuel H. Tuskey ADDRESS 57 Shb...

...mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... at it may be properly classified. Exact statement of ... on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59547

CERTIFICATE OF DEATH.

D 59547

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1014 Division ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Blow Beale.

(a) RESIDENCE. NO. 1314 Park Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	American-white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Beale

6 DATE OF BIRTH (month, day, and year) May 28, 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent of railroad.

(b) General nature of industry, business, or establishment(in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia

PARENTS

10 NAME OF FATHER Joseph Beale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Ada Blow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Elizabeth Beale
(Address) 1074 Park Ave

15 Filed . 19 Registrar
DEC 22 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1921, to Dec 21, 1921, that I last saw h[im] alive on Dec. 21, 1921, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Visceral carcinomatosis-metastatic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 16, 1921

Was there an autopsy?

What test confirmed diagnosis? Operation & clinical course

(Signed) [illegible], M. D.

Dec 22 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12-23 1921
20 UNDERTAKER Everyd Jenkins & Sons Co.	ADDRESS 1426 Eutaw Pl & Eutaw & Richard

NOTE—Information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59548

D 59548

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 Woodbrook Ave. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Louis Mormann

(a) RESIDENCE NO. 2520 Woodbrook Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaretha Mormann

6 DATE OF BIRTH (month, day, and year) Feb. 25th 187-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	9	26	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Machinist for

(b) General nature of Industry, business, or establishment in which employed (or employer) Tidewater

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gustav Mormann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Mathilda Wachtel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wallace Schaeffer (Address) 2520 Woodbrook Ave.

15 Filed DEC 22 1921 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21st 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19 21 to Dec. 21 19 21, that I last saw h[illegible] alive on Dec 21 19 21, and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pulmonitis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) C. Fiske M. D.

Dec. 19 21 (Address) 1735 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Co. DATE OF BURIAL Dec 24 19 21

20 UNDERTAKER Joseph B Cook ADDRESS 403 N Bally

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE at last birthday. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—B. P. Co.—1000 Blks.

D 59549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 108 091 D 59549

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hobbs.

(a) RESIDENCE. No. 313 N. Eden ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Hobbs

6 DATE OF BIRTH (month, day, and year) 8-30-92

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Daniel Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Josephine Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Records

15 Filed DEC 22 1921 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-5, 1921, to 12-21, 1921, that I last saw h[illegible] alive on 12-21, 1921, and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

1 Bronchopneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Appendicitis, a cute.

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? At hospital

Did an operation precede death? Yes Date of Nov. 5, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil A. Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emporia Va	Dec 22 1921
20 UNDERTAKER John W Henderson	ADDRESS 150 E main

Be sure that it may be properly ... mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59550

D 59550

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 725 N. Henry St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stoebener

(a) RESIDENCE No. 1725 N. Henry St., 21 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Stoebener

6 DATE OF BIRTH (month, day, and year) Feb 9-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinetmaker
(b) General nature of industry, business, or establishment in which employed (or employer) 017
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Unknown.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. H. Stoebener, 1
(Address) 1725 N. Henry St.

15 Filed DEC 22 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 21, 1921, that I last saw h[illegible] alive on Dec 20, 1921, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Paralysis (cerebral)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, (senile insanity) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E. Treadgar, M. D.

Dec 21, 1921 (Address) 2002 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 23 1921
20 UNDERTAKER	ADDRESS
Geo Lewis Lock & Son	647 N. Pa. Ave.

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. Any information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—B. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 59551

D 59551

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 719 S. Port ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kriz

(a) RESIDENCE. NO. 719 S. Port ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? 44 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Widow

6a If married, widowed, or divorced: (or) WIFE of late Charles Kriz

6 DATE OF BIRTH (month, day, and year) Oct 3/ 1838

7 AGE: Years 83 Months 2 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Josephine Roubal 719 S. Port St.

(Address)

15 DEC 22 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Dec 17 1921, that I last saw h— alive on Dec 19 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. L. Levy, M. D.

Dec 21 1921 (Address) 1701 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 23 21

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE cannot be properly classified, nor information should be carefully supplied, so that it may be preserved in plain terms, so that it may be preserved of certificates. CAUSE OF DEATH in plain terms, so that it may be preserved of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59552

CERTIFICATE OF DEATH.

79 D 59552

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 238 N. Mount (St.:) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos P. Talbott

(a) RESIDENCE. No. 238 N Mount St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida B. Talbott

6 DATE OF BIRTH (month, day, and year) Aug 24 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hucksters

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Charles Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Duckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C. C. Talbott

(Address) 238 N Mount

15 DEC 22 1921 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 21, to Dec 20, 19 21, that I last saw h alive on Dec 20, 19 21, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Howard Wright, M. D.

, 19 (Address) 1901 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 23 19
20 UNDERTAKER	ADDRESS
Smith Undertaking Co.	

N. B.—Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Comings

HEALTH DEPARTMENT—CITY OF BALTIMORE

108 D 59553

59553

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Union Memorial Hospital. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

2-FULL NAME Harry Comings

(a) RESIDENCE. NO. 631 Pitcher St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Comings

6 DATE OF BIRTH (month, day, and year) Jan 15. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Comings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Patient (Harry Comings)

(Address)

15 Filed DEC 22 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1921, to Dec 21, 1921, that I last saw him alive on Dec. 21, 1921, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus (?)

(duration) yrs. mos. 8-12 hrs ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. few hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec. 19, 1921

Was there an autopsy? no. Clinical course

What test confirmed diagnosis?

(Signed) J. W. Kinney, M. D.

Dec 21 1921 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrer Knecedale

DATE OF BURIAL 12/22 1921

20 UNDERTAKER Jack Laws ADDRESS 1411 E Balto

N. B.—Information should be carefully answered, so that it may be plain terms, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic appendicitis
Operation for abscess.
Phy. does not think
appendicitis had any
direct bearing on death.
Cause of embolus unknown.
No further history.

Spec.—1-10-21—M&T 1500 Blks.

D 59554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92D 59554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Cook Ave ST. 26 WARD) Rosebury

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob J. Sachs

(a) RESIDENCE NO. 1 Cook Ave ST. ..... WARD Rosebury V.A.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sylvia Sachs

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Baltimore~~ N.Y.

PARENTS

10 NAME OF FATHER Simon Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E. Baltimore St.

15 Filed DEC 27 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24/21

17 I HEREBY CERTIFY, That I attended deceased from Dec 18/21, 19..., to Dec 24/21, 19...

that I last saw him alive on Dec 21/21, 19...

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) (1st) yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia (duration) Sudden yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? ..... Date of /

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) H. S. Hauck M. D.

(Address) 1477 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herron Memorial Park — DATE OF BURIAL 12/23 1921

20 UNDERTAKER Jack Laurs 1411 E Balt — ADDRESS

N. B.—WRITE plainly. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.-1-10-21-M&T-1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59555

CERTIFICATE OF DEATH.

46 D 59555

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hosp ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lily David

(a) RESIDENCE NO. 1707 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meyer David

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bernard Kloff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Baltimore St

15 Filed DEC 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-19-21, 19 , to 12-22, 1921, that I last saw h alive on 12-22-21, 1921, and that death occurred, on the date stated above, at 4.55 P.M.

The CAUSE OF DEATH* was as follows:

Post operative shock

(duration) yrs. mos 1 has

CONTRIBUTORY (Secondary) Hypertrophied uterus

(duration) ? yrs. 6 mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12. 21-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest Eckhardt M. D.

12/22 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 12/23 1921

20 UNDERTAKER Jack Lewis 1411 E Balt — ADDRESS

N. B.—WRITE PLAINLY. All information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5955

CERTIFICATE OF DEATH.

28

D 59556

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Main St Arlington 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mabey

(a) RESIDENCE NO. 5 main St Arlington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amhose Mabey

6 DATE OF BIRTH (month, day, and year) Sept. 12 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	40	3	8	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laboring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Garrison Garage

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Amhose Mabey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Emma J Mabey (Address) 5 main St Arlington

15 Filed DEC 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from Oct 1921, to Dec 20 1921, that I last saw him alive on Dec. 20 1921, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows: Tuberculosis, (Pulmonary & Laryngeal)

(duration) yrs. 5-6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of occupation

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Henry Cecil M. D.

19 (Address) 3402 Woodland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Dec 23 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E Mulberry Ave

N. B.—WRITE PLAINLY. Answers to questions should be carefully supplied. Accurate information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 59557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 59557

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Burgess

(a) RESIDENCE. NO. 1425 S. Hanover St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Married~~ Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Burgess

6 DATE OF BIRTH (month, day, and year) March 21, 1851.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife. H-D

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER John Tusey

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Ellen Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant W. D. Atkins

(Address) 1425 Hanover St.

15 Filed . 19 Registrar

DEC 22 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1921. to Dec. 20, 1921. that I last saw h.. alive on Dec. 20, 1921. and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis
Cardiac dilatation
Cardiac decompensation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) J. Wilkie Hampton, M. D.

. 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood. Dec	23/21. 19

20 UNDERTAKER W. M. Cook

ADDRESS 502 E. Hoffman St

N. B.—WRITE PLAINLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 59558

D 59558

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C 10

CITY OF BALTIMORE (No. 410 N. Carrollton Ave WARD)

(If death occ... a hospital or inst... give its NAME ins... street and numb... fill out No. 18.)

2-FULL NAME Mary Jane Stafford

(Residence in Baltimore: No. 410 N. Carrollton St. 78 yrs. — mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Oct 9, 1843 (Month) (Day) (Year)

7 AGE: 78 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Patrick Hughes

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McCausland

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mallard

(Address) 410 N. Carrollton Ave

15 Filed DEC 22 1921 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 20, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-10-21, 191 , to 12-20-21, 19

that I saw h[illegible] alive on 12-19-21, 19

and that death occurred, on the date stated above, at 5[illegible]

The CAUSE OF DEATH* was as follows:

La Grippe

10 days
(Duration) yrs. mos.

Contributory (SECONDARY) Hypostatic Pneumonia 2x Lm

(Duration) yrs. mos.

(Signed) Arthur G. Barrett

12-21, 1921 (Address) 2000 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT C... state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICI... HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS... OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. | In the ds. State ... yrs. ... mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral | DATE OF BURIAL: 12-23rd

20 UNDERTAKER: H. C. Brannigan Son | ADDRESS: 17 N. Schroeder St.

N. B.-Every item of information should be carefully supplied. AGE should be stated... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Mienot Winters

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 59559

CERTIFICATE OF DEATH.

D 59559

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lakeland Belvedere Ave St.) 22 (WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mienot Winters

(Residence in Baltimore: No. Lakeland Belvedere ave St.) 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 28, 1905
(Month) (Day) (Year)

7-AGE, 16 yrs. 7 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer). ....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Winters

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Schutt

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Winters

(Address) Lakeland

15-
DEC 22 1921
Filed....., 191.....
ROBERT R. KRAUTER,
Registrar.
Burial Permit

N. B.—Every item of information should be given if possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1921, to Dec 21 1921, that I saw h in alive on Dec 20 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) No yrs. 9 mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

Heart D. (Duration) No yrs. No mos. 1 ds.

(Signed) Raymond V. Gilmore M. D.

Dec 21, 1921. (Address) Lakeland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 12-24-1921

20-UNDERTAKER H C Brammer Son

ADDRESS 517 N. Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59560

CERTIFICATE OF DEATH.

D 59560

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1517 N. Gilmor ST.: 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Callahan

(a) RESIDENCE NO. 1517 N. Gilmor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence P. Callahan

6 DATE OF BIRTH (month, day, and year) May 3rd 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Patrick O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Lawrence P. Callahan 1517 N. Gilmor St

15 Filed DEC 22 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1921, to Dec 20th, 1921, that I last saw h[illegible] alive on Dec 20th, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Urinalysis

(Signed) William J. Sullivan, M. D.

12/22/1921 (Address) 1701 W. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 22nd 1921

20 UNDERTAKER Martin Fisher & Sons ADDRESS 1827 W North Ave

N. B.—Information should be carefully supplied, so that it may be properly CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

59561

59561

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Kletter

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevadore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed . 19 ROBERT R. KRAUTER, Registrar

DEC 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from December 12, 1921, to December 19, 1921

that I last saw him alive on December 19, 1921

and that death occurred, on the date stated above, at 11:50 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

N. B.—WRITE PLAINLY. Every question should be carefully answered, so that it may be properly classified. Information should be carefully supplied. Abbreviations should not be used in answering questions. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59562

CERTIFICATE OF DEATH.

1920

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

2-FULL NAME Etta S. Ruddach

(a) RESIDENCE. NO. 648 N. Carey ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word)
Female	White	Widow

5a If ~~married~~ widowed, ~~or divorced~~ (or) WIFE of Charles W Ruddach

6 DATE OF BIRTH (month, day, and year) Aug - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cut

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER John Bowman

11 BIRTHPLACE OF FATHER (city or town) Harford Co (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca J. Bowman

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country) Md

14 Informant (Address) Geo W Little 2700 Edmondson Av

15 Filed DEC 22 1921 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July . 1921 , to Dec 20 . 1921 .

that I last saw her alive on Dec 20 . 1921 .

and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Osmond Purnell M.D. M. D.

Dec 23 1921 (Address) 103 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rocky Run Cemetery Harford Co Md

DATE OF BURIAL Dec 23 1921

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Av

N. B.—WRITE PLAINLY. All items must be carefully supplied. And the information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59563

CERTIFICATE OF DEATH.

D 59563

79 REGISTERED NO.

1-PLACE OF DEATH Angela

CITY OF BALTIMORE: (No. 812 Eastern ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angela Chiesa

(a) RESIDENCE. NO. 812 Eastern ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Chiesa

6 DATE OF BIRTH (month, day, and year) May 30 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Chiesa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Girolmo Raggi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) John Chiesa # 911 Eastern Washington

15 DEC 22 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921, to Dec. 21, 1921, that I last saw h e alive on Dec. 20, 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno M. D.

Dec 22, 1921 (Address) 2m Stiles - Balto md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dk. St Vincent

DATE OF BURIAL Dec 24 1921

20 UNDERTAKER Wendell Diffel

ADDRESS 378 Hmm

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of information should be carefully supplied. AGE may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 59564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59564

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Gracik

(Residence in Baltimore: No. 626 S. Bond St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Wid

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wood cutter
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Robert F. Harrison,

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Sudden (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Dec 14, 1921. (Address) 1639 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

DEC 22 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully examined, so that it may be properly classified. EXACT CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

JOHNS HOPKINS HOSPITAL
Commissioner Health
Per. Wm. H. Woodall

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59565

CERTIFICATE OF DEATH.

151 D 59565

1-PLACE OF DEATH West End Maternity

CITY OF BALTIMORE: (No. 112 N. Calhoun ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Archer Enrico

(a) RESIDENCE NO. Rossville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec - 1 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) W. E. Md. Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Harry J. Enrico

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Helen M. Archer

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Harry J. Enrico
(Address) Rossville Sta. Run Md.

15 Date DEC 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec - 13 21, 1921, to Dec - 21 22, 1921, that I last saw h[illegible] alive on Dec - 21 22, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) yrs. mos 2d ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Newton D Carr M. D.

, 19 (Address) 1530 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cmetery	Dec 23d 1921
20 UNDERTAKER	ADDRESS
Walter W. Shriver	1018 Edmondson Ave.

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that its nature may be clearly understood.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59566

CERTIFICATE OF DEATH.

91-0 19D 59566

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Emerson main Apt ST.: 13 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm B. Schoen

(a) RESIDENCE. No. Eutaw Place 41 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or, WIFE of): Rosa Schoen

6 DATE OF BIRTH (month, day, and year): Oct 13th 1843

7 AGE — Years: 78 Months: 2 Days: 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ladies, outfitting

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr Schoen Emerson apt

15 Filed Dec 22 1921, 19 Robert [illegible] Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27th, 1904, to Dec 22, 1921, that I last saw h[illegible] alive on Dec 22, 1921, and that death occurred, on the date stated above, at 1240 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiitis (duration) 48 yrs. ! mos. ds. Asthma bronchial; uraemia

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P Hamburger, M. D.

Dec 22, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew — DATE OF BURIAL: Dec 23 1921

20 UNDERTAKER: Wm H Sondheim — ADDRESS: 1184 Eutaw

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 59567

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1940 McHenry ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugo Tillmann

(a) RESIDENCE. NO. 1940 McHenry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 22, 27

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farm

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Hugo Tillmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Bellenger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Mrs H Tillmann (Address) 1940 McHenry St

15 Filed DEC 23 1927 ROBERT R. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1927, to Dec 22, 1927, that I last saw him alive on Dec 22, 1927, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows: Premature delivery at 6th Month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Howard W Jones M D

19 (Address) —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 23 1927

20 UNDERTAKER: Wm Mrs A J Smith — ADDRESS: 1535 N Broadway

mation should be given in plain terms, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59568

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1455 Hull ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Girard Anthony White

(Residence in Baltimore: No. 1455 Hull St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
mah	White	Sing'l

6-DATE OF BIRTH, Sept (Month) 21 (Day), 1921 (Year)

7-AGE, ...yrs. 3 mos. ... ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph White

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine Fengel

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph White

(Address) 1455 Hull St

15- Filed DEC 23 1921, 19... ROBERT R. KRAUTER, Registrar.

Burial Permit

N. B. CAUSE OF DEATH in plain terms. Be sure to answer all questions. Every question important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1921, to Dec 22 1921, that I saw him alive on Dec 21 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

Spina Bifida

(Duration) ...yrs. 3 mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. 3 mos. ...ds.

(Signed) W. L. Smith M. D.

Dec 22, 1921. (Address) 1455 Hull St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Balto — DATE OF BURIAL, 12-24, 1921.

20-UNDERTAKER Ed B Starke — ADDRESS 115 E West St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59569

CERTIFICATE OF DEATH.

37 D 59569

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marion Davis

(a) RESIDENCE. NO. 11 N. Arch St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Black.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER T. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Lottie Ancrum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Geo. Davis
(Address) 11 N. Arch st.

15 Filed DEC 23 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1921. to Dec. 20, 1921. that I last saw h.. alive on Dec. 20, 1921. and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation
" hypertrophy
" dilatation.
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical symptoms.

(Signed) J. Willis Hunton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Yamassee Ga

DATE OF BURIAL Dec 23 1921

20 UNDERTAKER Yamassee Ga

ADDRESS —

B and ORR & Coast Line

mation should be entered in plain terms, so that it may be readily understood. CAUSE OF DEATH in plain terms, so that it may be readily understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Wasserman positive.

Luetic infection.

Spec.—1-10-21—M&T—1500 Bks.

D 59570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9V D 59570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sherwood Hotel 212 W. Monument ST., WARD)

2-FULL NAME Laura de Goey

(a) RESIDENCE NO. 212 W. Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wm. de Goey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliz. Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Virginia de Goey
(Address) 212 W. Monument

15 Filed DEC 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1921, to Dec 21, 1921, that I last saw h alive on Dec 21, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas B Freeman, M. D.

, 19 (Address) 412 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mound	Dec 23 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 N. Eutaw St.

...mation should be carefully supplied, so that it may be properly ...
CAUSE OF DEATH in plain terms, so that it may be properly ...
TION is very important. See instructions on back of certificates.

D 59571

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D 59571

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 Olive St. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William H. Young. (C) St.; 33 yrs., ------ mos., ------ ds.)

(Residence in Baltimore: No. 1112 Olive St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. Do not know. (Month) ....., (Day) 1 (Year)

7-AGE. 45 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE. (State or Country). Wilmington. Del.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Washington. (C)

(Address) 118 W. Henrietta St.

15- Filed DEC 23 1921 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 3rd. 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.
Pulmonary Tuberculosis.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. M. Reinhardt M. D.
(Coroner) (Address) Dec. 21., 1921 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).
At place of death.... yrs. ..... mos. ..... ds. In the State.... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ... DATE OF BURIAL, ..., 19...

20-UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL
Commissioner Health.
DEC 2 1921
MAY WM E. WOODALL

N. B.—Every item of information should be carefully written, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Early attention to this is important. See instructions on back of certificate.

George A. Helmer

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59572

CERTIFICATE OF DEATH.

144

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) St. Joseph's Hosp. (ST.: 10 WARD)

2-FULL NAME George A. Helmer.

(a) RESIDENCE NO. 921 N. Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed or divorced, HUSBAND of (or WIFE of) Marie E. Helmer

6 DATE OF BIRTH (month, day, and year) February 20 1896

7 AGE: Years 25 Months 10 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Printer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Alphonse Helmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Sophia Ackermann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Mrs. Marie E. Helmer 921 N. Eden St.

15 Filed DEC 23 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1921 to Dec 22 1921

that I last saw h— alive on Dec 22 1921

and that death occurred, on the date stated above, at 12.10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Abscess neck.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 18

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Minnick, M. D.

(Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL Dec. 26 1921

20 UNDERTAKER: Henry Hoeck & Son ADDRESS 1301 E. Lanvale

mation should be carefully answered, so that it may be property of certificates.

CAUSE OF DEATH in plain terms, so that it may be

TION is very important. See instructions on back of

Chaim Loobani

59573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 59573

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 E. Baltimore St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2 FULL NAME Chaim Loobani

(Residence in Baltimore: No. 1509 E Baltimore St

16 St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): M

6-DATE OF BIRTH: ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE: 59 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Burlap 045
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Samuel Moses

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unkam

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Louis

(Address) 1411 E Balto St

15-

Filed DEC 23 1921 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: 12/22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... inquisition ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Henry Gill M. D.
(Coroner)

Dec 22, 1921 (Address) 1509 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 12 23 1921

20-UNDERTAKER: Jack Louis

ADDRESS: 1411 E Balto St

N.B.—Every item of information should be carefully ... CAUSE OF DEATH in plain terms, so that it may be ... important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59574

64-091

D 59574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Herzog

(a) RESIDENCE NO. 1400 Wagner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs M Herzog

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery 134

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Balto St

15 Filed DEC 23 1921 ROBERT R. KRAMER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/22 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/10/21, 19, to 12/22/21, 19, that I last saw him alive on 12/22/21, 19, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Terminal

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage & Hypertension

(duration) yrs. mos. 14 ds. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I Herzberg, M. D.

12-22-1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 12/23 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

mation should be carefully ... it may be prepared. CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59575

CERTIFICATE OF DEATH.

108 # 59575

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Franklin Square Hosp. ST.) 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Kolodner

(Residence in Baltimore: No. 1131 W. Franklin St 41 25 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) Jan 27 (Day), 1883 (Year)

7-AGE, 38 yrs. 11 mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Real estate Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jerrim Kolodner

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dora Morlnick

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Baltimore St

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, so that certificate may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1921, to Dec 22 1921, that I saw h[illegible] alive on Dec 22 1921, and that death occurred, on the date stated above, at 2.05 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) — yrs. — mos. 7 ds.

(Signed) H. C. Wallick M. D.

Dec 23 1921 (Address) Franklin Sq Hosp,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 6 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 1131 W Franklin St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	Dec 23, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Baltimore St

Spmc—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59576

CERTIFICATE OF DEATH.

1547 D 59576

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 426 E Fort Ave ST.: 24 WARD)

2-FULL NAME Thomas James Mc Quay.

(a) RESIDENCE No 426 E Fort Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena B Mc Quay

6 DATE OF BIRTH (month, day, and year) Aug 30 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bozman Talbot Co Md

PARENTS

10 NAME OF FATHER Patrick Mc Quay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bozman Talbot Co Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lena B Mc Quay (Address) 426 E Fort Ave

15 Filed DEC 23 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1921, to Dec 21, 1921, that I last saw him alive on Dec 21, 1921, and that death occurred, on the date stated above, at -- p. m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Senile (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Smith M. D.

Dec 23 1921 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL John H. Denny

DATE OF BURIAL Dec 23 1921

20 UNDERTAKER H. Michaels Md

ADDRESS 715 Light

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not known. No further history.

D 59577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168

D 59577

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1925 Ridgewood Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua N. Sneeden

(Residence in Baltimore: No. 1925 Ridgewood Ave St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Widower

6-DATE OF BIRTH. Dec. 20, 1841
(Month) (Day) (Year)

7-AGE. 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): no occupation

9-BIRTHPLACE, (State or Country). Germany,

PARENTS.

10-NAME OF FATHER. Henry

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER Krum

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Sneeden

(Address) 1917 W. Lanvale St

15-
Filed DEC 23 1921 19t. ROBERT R. KRAUTER,
Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas (illuminating)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Dec. 20 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Weston Cemetery	Dec 23, 1921
20-UNDERTAKER	ADDRESS
Josiah Seffer	1601 W North Ave

N. B.—Every item of information should be carefully supplied. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

59578

HEALTH DEPARTMENT—CITY OF BALTIMORE

59578

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimor Md. ST., 24 WARD)

2-FULL NAME George L. Wilson

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., -- WARD --
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger 086

(b) General nature of Industry, business, or establishment in which employed (or employer) ------

(c) Name of employer --------

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrook Registrar
(Address) US. PHS Hosp. #56 Balto. Md.

15 Filed DEC 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1921, to Dec. 22, 1921.

that I last saw him alive on Dec. 22, 1921.

and that death occurred, on the date stated above, at 2'30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. & active

Oct. 27, 1921 (duration) - yrs. ---- mos. ---- ds.

CONTRIBUTORY (Secondary) ---------- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas B. Payne M. D.
Senior Surgeon (R)

12/22 1921 (Address) US. PHS. Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. National Cemetery — DATE OF BURIAL Dec 23 1921

20 UNDERTAKER S. Swanson & Bro — ADDRESS 1127 E. Balto St

Information should be carefully supplied, so that it may be properly transcribed. CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates. ATION is very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59579

CERTIFICATE OF DEATH.

X 79 D 59579

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.:) 4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James Owens

(a) RESIDENCE (No.) Argyle Hotel (St.) Balto Md. (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 26, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mercy Hosp. Record
(Address)

15 Filed . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1921, to DEC 22, 1921,

that I last saw him alive on DEC 22, 1921,

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio-Salerosis
& Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema (duration) 33 minutes yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) John L. Eshelman, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL S. Annapolis Md — DATE OF BURIAL Dec 23 1921

20 UNDERTAKER Jas L. Taylor Sons — ADDRESS Annapolis Md.

mation should be given in plain terms, so that it may be understood by persons not familiar with technical terms. CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with technical terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59580

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59580

X 170

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Doolin

(a) RESIDENCE NO. Mount Hope Retreat ST., 28th WARD. Frostburg Md

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? 64 yrs. 3 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Doolin

6 DATE OF BIRTH (month, day, and year) Sept 18 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	64	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frostburg Md

PARENTS

10 NAME OF FATHER Mathew Carney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Longford Ireland

12 MAIDEN NAME OF MOTHER Catteran Kenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Longford Ireland

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md.

15 Filed DEC 23 1921 J E Walsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 13th, 1921, to Dec 22, 1921, that I last saw her alive on Dec 22, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Melancholia

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Frostburg Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frostburg - Md

DATE OF BURIAL Dec 23/21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be classified. See back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59581

CERTIFICATE OF DEATH.

D 59581

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) #5901-Bellona-Ave. (ST.) 27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Virginia Ogier.

(a) RESIDENCE. NO. #5901-Bellona-Ave. ST. 27 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? 49 yrs. 5 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) July-11-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: John S. Ogier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Mary E. Burgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant (Address): John S. Ogier, (father) 5901-Bellona-Av., City.

15 Filed DEC 13 1921 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-21st 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1919, to Dec 21st, 1921, that I last saw h[illegible] alive on Dec. 21st, 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 18 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & sputa tests

(Signed) Dr. S. Dabney, M. D.

Dec 23 1921 (Address) Easton, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GREEN MOUNT CEMETERY	DEC-23-21
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

IMPORTANT—Write CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59582

CERTIFICATE OF DEATH.

4 79 D 59582

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1700 block Edmondson Ave ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. N. Krafft

(Residence in Baltimore: No. 112 N. Green St. St.; 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Mar'd

6-DATE OF BIRTH, Aug. 11, 1865
(Month) (Day) (Year)

7-AGE. 56 yrs. 4 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Oil

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Martin Krafft

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Barbara Standitz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. N. Krafft

(Address) Edmondson Ave.

15- Filed DEC 23 1921 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

N. B.—Every item of information must be given in plain terms, so that it may be properly understood. CAUSE OF DEATH must be stated in such terms as will show the disease, the part of the body affected, and the nature of the injury, if any, which caused death. Merely local terms of disease, or terms which are indefinite or misleading, cannot be used. If the disease was of a contagious nature, the fact should be stated. If the deceased was a married woman, the fact should be stated. The information required in answer to each question is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (acute)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. H. Hemmeter M. D.
(Coroner)

Dec. 21, 1921 (Address) 2 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Dec. 23, 1921

20-UNDERTAKER F. D. Metzger

ADDRESS 1111 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

59583

HEALTH DEPARTMENT—CITY OF BALTIMORE

59583

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Reynolds st ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LOUISE BOYLE

(a) RESIDENCE. NO. 1407 Reynolds ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

Sa[redacted] married, [redacted] WIFE of John Boyle

6 DATE OF BIRTH (month, day, and year) Sept 5 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Stoos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER [illegible] Trautman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Boyle (Address) 1407 Reynolds St

15 Filed DEC 23 1921 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from February 25 19 [illegible], to Dec 20, 19 21.

that I last saw her alive on Dec 19, 19 21.

and that death occurred, on the date stated above, at 11 05 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 9 mos. 25 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 2.25.20

Was there an autopsy? No

What test confirmed diagnosis? Laboratory at Hosp

(Signed) [illegible] M. D.

12/20 19 21 (Address) 2578 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	12/23/21 19
20 UNDERTAKER John J Pahey & Sons	ADDRESS 1210 Light St

mation should be given in plain terms, so that it may be understood by the general public. CAUSE OF DEATH in plain terms. so that it may be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59584

CERTIFICATE OF DEATH.

37-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Mack

(a) RESIDENCE. NO. 1348 N. Stockton St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed . 19 12/21/19 21 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1921, to December 20, 1921, that I last saw her alive on December 20, 1921, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Syphilis — Residual Hemiplegia right (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. A. McCay, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters cemetery	Dec. 23 1921
20 UNDERTAKER Joseph A Farrell	ADDRESS 2314 Division

IMPORTANT.—Fill out this certificate in plain terms, so that it can be understood. Write CAUSE OF DEATH in plain terms. See that it is signed on back of certificates. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59585

CERTIFICATE OF DEATH.

170 D 59585

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Belair Road ST., 27 WARD)

2-FULL NAME Helen Franz

(a) RESIDENCE NO. 512 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred one yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Neither

6 DATE OF BIRTH (month, day, and year) Nov 12 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Helen Franz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Joseph Franz
(Address) 512 Belair Road

15 Filed DEC 23 1921 19.. Registrar

ROBERT GRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 21 1921

17 I HEREBY CERTIFY, That I attended deceased from December 16, 1921, to December 21, 1921, that I last saw her alive on December 21, 1921, and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Primary)

(duration) 11 yrs mos ds.

CONTRIBUTORY (Secondary) Uremia - Convulsions and Coma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Thomas J Simms, M. D.

, 19 (Address) 1026 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 12/24 1921

20 UNDERTAKER William Cook

ADDRESS 502 E North

mation should be given in plain terms, so that it may be understood by the general public. See instructions on back of certificates.
CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59586

D 59586

CERTIFICATE OF DEATH.

18

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Homestead ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schneider

(a) RESIDENCE NO. 1137 Homestead ST., 9th WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry A Schneider

6 DATE OF BIRTH (month, day, and year) apr 14 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Tine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman F Otto
(Address) 1137 Homestead.

15 Filed DEC 23 1921 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1921, to Dec 22, 1921,
that I last saw h/e alive on Dec 22, 1921,
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Septic arthritis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Dig Sepelas ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N Meyer Jr. M. D.

12/23/1921 (Address) 2638 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz

DATE OF BURIAL Dec 24 1921

20 UNDERTAKER Wm Cook

ADDRESS 502 E Monument

mation should be given in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—4-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59587

CERTIFICATE OF DEATH.

79 D 59587

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 N. Charles ST. 17 WARD)

2-FULL NAME Nancy Freeland

(a) RESIDENCE No. 2101 N. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Freeland

6 DATE OF BIRTH (month, day, and year): May 31 - 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs or ___ min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Bertha Reese

(Address): 2105 N. Charles

15 Filed DEC 22 1921 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23d 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 23d, 1921, to Dec 23d, 1921, that I last saw h.. alive on Dec 23d, 1921, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

Few hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. N. Pegram, M. D.

Dec 23, 1921 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 12/26 1921

20 UNDERTAKER: Mullan Cook — ADDRESS: 501 E. North

mation should be given in plain terms, so that it may be properly classified. If the CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Myocarditis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59588

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Luzerne ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther S. Horne

(a) RESIDENCE. NO. 203 N. Luzerne ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Luther S. Horne

11 BIRTHPLACE OF FATHER (city or town) Surry Co Va (State or country)

12 MAIDEN NAME OF MOTHER Ruth Konkel

13 BIRTHPLACE OF MOTHER (city or town) New York Penn (State or country)

14 Informant Bro S. Konkel

(Address) 203 N. Luzerne

15 Filed DEC 23 1921 19 ... Registrar

ROBERT H. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22 1921

17 I HEREBY CERTIFY, That I attended deceased from December 19. 1921. to December 22. 1921.

that I last saw him alive on December 21. 1921.

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr G W Kennard M. D.

12-22-1921 (Address) 708 Bumson 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 24th 1921
20 UNDERTAKER	ADDRESS
Wm Schumacher Sons	946 Argyle Ave

CAUSE OF DEATH in plain terms, so that it may be classified. See back of certificates.
TION is very important.

D 59589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59589

CERTIFICATE OF DEATH.

X 92

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Brown — City Jail

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1895 (Year)

7-AGE, 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Norfolk Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address)

15- DEC 23 1921 ROBERT R. KRAUTER, Burial Permit Registrar.

Filed, 191

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Mercy Hosp. find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Grippe (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.) M. D.

Dec 22, 1921 (Address) 1632 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Norfolk, Va

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem DATE OF BURIAL, Dec 23 1921

20-UNDERTAKER Saml S Beasley ADDRESS 378 N Bradford

N.B.—Every item of information should be given, so that it may be properly classified. Be sure to fill out CAUSE OF DEATH in plain terms, as that is the most important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

59590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N Duncan ST.: 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Venia Travers

(Residence in Baltimore: No. 505 N Duncan St.: 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH. Dec 24, (Month) (Day) 1843 (Year)

7-AGE, 77 yrs. 11 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Dorchester Co. Md

PARENTS.

10-NAME OF FATHER. Jacob Cooper

11-BIRTHPLACE OF FATHER (State or Country). Dorchester Co. Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Dorchester Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Cooper

(Address) 505 N Duncan St

15-

Filed DEC 23 1921, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms. Items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1921, to Dec 20 1921, that I saw her alive on Dec 19 1921, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) Chas. C. Eisenhart M. D.

Dec 20, 1921. (Address) 2211 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bethel Cemetery	Dec 24, 1921
20-UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59591

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59591

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE (No. St. Joseph's Hospital ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Denner

(a) RESIDENCE. No. 1802 Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Not Known 1846

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush Maker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

986

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Denner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Gapsky 1216-E. Biddle St.

15 Filed ....., 19

Burial Permit Clerk. Registrar

EC 23 1921

CAUSE OF DEATH in plain terms. So that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22, 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to Dec 22, 1921, that I last saw him alive on Dec 22, 1921, and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman J. Dorf, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	12/24/21
20 UNDERTAKER George J. Ruth.	ADDRESS 1735 Hanford Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59592

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Fleishman.

(a) RESIDENCE NO. Seton Valley Co. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Michael Fleishman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84.	"	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home..

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Basil Naad.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Cecelia Lauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Superior..
(Address) Little Sisters of the Poor

15 DEC 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,
that I last saw h.. alive on Dec 18, 1921,
and that death occurred, on the date stated above, at 6.30 P.m.
The CAUSE OF DEATH* was as follows:

Myocarditis of foot NW

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Moser, M. D

Dec 23, 1921 (Address) 1123 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Dec	24 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	1st Fremont

CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with medical terms. See instructions on back of certificates. TION is very important.

...ITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Diabetes.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59593

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 S. Third ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Maloy.

(a) RESIDENCE. NO. 1006 S Third ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Margaret Maloy.

6 DATE OF BIRTH (month, day, and year) Sept 7-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Chester Pennsylvania

PARENTS
10 NAME OF FATHER Terrence Maloy.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.
12 MAIDEN NAME OF MOTHER Martha Nash
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address) Margaret Maloy 1006 S. Third St.

15 Filed ....., 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

C 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1921, to Dec. 21, 1921, that I last saw him alive on Dec. 21, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Forbes Cochran, M. D.

, 19 (Address) 806 S. Third St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 24th 1921
20 UNDERTAKER Lilly & Son	ADDRESS 403 S. Wolfe St.

Information should be written in ink, in plain terms, so that it may be easily read. Do not abbreviate. See back of certificates.
CAUSE OF DEATH in plain terms, so that it may be easily read. Do not abbreviate. See back of certificates.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59594

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D 59594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1210 S. 3rd St. (Ward) 26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ladner

(a) RESIDENCE NO. 1210 S. 3rd St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Catherine Ladner

6 DATE OF BIRTH (month, day, and year) 4.10.61.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	8	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Track Walker
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10 NAME OF FATHER: John Ladner
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Ellen Glenn
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Catherine Ladner
(Address) 1210 S. 3rd St.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12.21. 1921.

17 I HEREBY CERTIFY, That I attended deceased from November 24 19 20 to December 21 19 21
that I last saw him alive on December 20 19 21
and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Hemiplegia (Paresis)
duration 1 yrs. mos. ds.

Acute Bronchitis
CONTRIBUTORY (Secondary)
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. Hollister A. Mey ed, M. D.
(Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec 24 1921
20 UNDERTAKER	ADDRESS
Lilly & Gieler	403 S. Wolfe St.

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59595

CERTIFICATE OF DEATH.

D 59595

REGISTERED NO. 70

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5012 Denmead Av ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward White Butler

(a) RESIDENCE. No. 5012 Denmead Av ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs 6 mos — ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or WIFE of) Emily Butler

6 DATE OF BIRTH (month, day, and year) Dec. 22. 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R. R.

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad - 078

(c) Name of employer State R. R.

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Elijah Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Rachel ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Margaret Hoffman
(Address) 5012 Denmead Av

15 Filed DEC 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 23, 1921, that I last saw h[illegible] alive on Dec 22, 1921, and that death occurred, on the date stated above, at 1 15 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs mos 3 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs 6 mos — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chemical & Clinical

(Signed) Charles J. Mills M. D.

, 19 (Address) 2 W Belvedere Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Dec 26 21
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W North Av

DEC 23 1921

CAUSE OF DEATH in plain terms, so that it can be understood by the average person. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59596

CERTIFICATE OF DEATH.

28 D 59596

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 313 Belair Road (ST.) Rasp (WARD) 28

2-FULL NAME Maggie D. Bell

(a) RESIDENCE NO. 313 Belair Road (ST.) Rasp (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Abraham Bell

6 DATE OF BIRTH (month, day, and year) Jan. 28th 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Robert Thompson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Rollin

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Abraham Bell
(Address) 313 Belair Road Raspberry

15 Filed , 19 Registrar

Robert P. Harrison,

DEC 23 1921

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to Nov 20th, 1921.

That I last saw h.r alive on Nov 20, 1921,

and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (Over)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert G Webster M. D.

, 19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec 24/1921
20 UNDERTAKER	ADDRESS
Fred Lacesmt & Sons	Baltimore

CAUSE OF DEATH in plain terms. SO that it may be understood. See instructions on back of certificates.
TION is very important

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59597

CERTIFICATE OF DEATH.

45 D 59597

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (a) NO. 3535 Hickory Ave ST., 13 WARD)

2-FULL NAME Sarah C. Webster

(a) RESIDENCE NO. 3535 Hickory Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michel G. Webster

6 DATE OF BIRTH (month, day, and year): March 17-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Maryland

PARENTS

10 NAME OF FATHER: Joseph Orf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Maryland

12 MAIDEN NAME OF MOTHER: Ruth Buckingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Maryland

14 Informant (Address): Mrs Ruth A. Payne 3535 Hickory Ave

15 Filed ..... 19 ..... Registrar: Robert P. Harrison

C 23 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10 1921, to Dec 22 1921.

That I last saw her alive on Dec. 22 1921.

and that death occurred, on the date stated above, at 12 25 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Humerus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Woodruff Read M. D.

(Address) 846 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 24 1921

20 UNDERTAKER: Horace H. Burgie — ADDRESS: 363 Fallsway

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59598

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. 1434 William ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida E. Butler

(a) RESIDENCE. NO. 1434 William ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W. Butler

6 DATE OF BIRTH (month, day, and year) Oct 22/1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nonne

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt Dedrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rachel Pelts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant John Butler (Address) 120 E. Randall St.

15 Filed Dec 28 1921 Robert P. Harrison Registrar

DEC 28 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Dec 23, 1921, that I last saw h[illegible] alive on Dec 23, 1921, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Ephamentia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Campbell, M. D.

Dec 23. 1921 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 26 1921
20 UNDERTAKER	ADDRESS
J. Fenw McCully	130 E Fay

N. B.—Information should be carefully supplied. Answers may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59599 — X 144 — D 59599

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. Broadway & Fayette St.) (WARD 6)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan C Davis

(a) RESIDENCE. NO..... STREET Church Home & Infirmary WARD. Norton Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W Lite	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Davis

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Funeral Directo

(b) General nature of industry, business, or establishment in which employed (or employer) Employer 116

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER H C Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sallie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Ellis Davis Deerayman. Va

15 Filed Dec 19 1921 Robert B. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 19 21, to Dec 23, 19 21, that I last saw him alive on Dec 23, 19 21, and that death occurred, on the date stated above, at 6:22 a. m.

The CAUSE OF DEATH* was as follows:

Lung abscess (1)
Multiple - Right Lung.

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov 19, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. of Lungs.

(Signed) W. A. Noble, M. D.

19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norton Va — DATE OF BURIAL Dec 26 1921

20 UNDERTAKER M E Grossom — ADDRESS 847 N 31st

DEC 23 1921

CAUSE OF DEATH in plain terms, so that it may be correctly classified. See back of certificates. TION is very important. See instructions on back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Cause of abscesses
unknown. Operation
for drainage of abscesses

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Wagner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59600

D 59600

64-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital Ward 24

CITY OF BALTIMORE: (No. ..... ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wagner

(a) RESIDENCE. NO. 1532 Wilkens ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Katherine Gilroy

(Address) 1532 Wilkens St.

15 Filed ..... 19 ..... Registrar

C 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-1-21, 19....., to 12-23, 1921, that I last saw h.r alive on 12-22-, 1921, and that death occurred, on the date stated above, at 11.30 A M 12.23 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Hemiplegia

Arteriosclerosis. OVER

3 day (duration) ..... yrs. ..... mon. ..... ds.

CONTRIBUTORY (Secondary) Fracture of hip

..... (duration) ? yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 0

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem exam

(Signed) Joseph B. Pincus M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 26/21
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E North Ave

CAUSE OF DEATH to be filled in plainly and completely. Information required is very important. See instructions on back of certificates.

Burial Permit Clerk

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pt'll ovr ~~sub~~ curt 9 mos ago.
Had terminal cerebral
hemorrhage.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59601 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59601

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1186 Hanover St.; 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert L. Miller,

(Residence in Baltimore: No. 1186 Hanover St.; 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, December 21, 1921.
(Month) (Day) (Year)

7-AGE, 53 yrs. 1 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon Keeper.
(b) General nature of industry, business, or establishment in which employed (or employer): Saloon, 1143

9-BIRTHPLACE, (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER. Joseph P. Miller.

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Nancy O'Leary,

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mason

(Address) 1603 Columbia Ave

15-

Filed ....., 191.....

Registrar.

DEC 28 1921

CAUSE OF DEATH to be filled in plain language. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 21, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1921, to Dec. 21, 1921, that I saw him alive on Dec 21, 1921, and that death occurred, on the date stated above, at 10.40 p m.

The CAUSE OF DEATH* was as follows:

I. Pulmonary Tuberculosis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos Horton M. D.

12/28, 1921 (Address) 888 W. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Dec. 25, 1921

20-UNDERTAKER Wm Cook

ADDRESS 501 E North Ave

Spec.—6-19—H. P. Co.—1000 Bks.

15 2167
12-2579

D 59602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ #5 D 59602

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St.: 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Gibson

(a) RESIDENCE. No. 1105 Ashland Ave St.. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) 1-17-51

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alex Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Blades

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address) Reisterstown

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

EC 23 1921

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21 1921

17 I HEREBY CERTIFY, That I attended deceased from 12- , 1921, to 12-21 , 1921, that I last saw him alive on 12-21 , 1921, and that death occurred, on the date stated above, at 8.40 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Dec 8 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil Holman , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto.	Dec 24/21
20 UNDERTAKER Wm Cook	ADDRESS 501 E North

CAUSE OF DEATH in plain terms. Statements of conditions as "Heart Failure," "Asthenia," "Old Age," "Senility," "Uremia," "Convulsions," "Cancer," "Tumor," are insufficient and unsatisfactory. Indefinite or incomplete answers to this question will cause return of certificate. Write plainly with pen and ink. Use no abbreviations. Do not state mode of dying, such as "Collapse," "Shock," "Hemorrhage," etc., but the disease causing it. Operations, accidents, and violence must be stated. Deaths from violence must be reported to the Coroner. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59603

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE (Usual place of abode) NO. 3508 Fairview ave ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Menslage

(a) RESIDENCE NO. 3508 Fairview ave ST.. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs mos 21 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	widower

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Ellen Menslage

6 DATE OF BIRTH (month, day, and year) Dec 4 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) WORK

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Fred. Menslage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Menslage

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant A. Golder (Address) 3508 Fairview ave.

15 Filed Robert P. Harrison Registrar

C 24 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 1921, to Dec 22 1921, that I last saw him alive on Dec 21 1921, 9:30 a m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Arterio sclerosis – myocarditis

Chronic interstitial nephritis.

(duration) yrs. ? mos. da.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Niblett M. D.

Dec 23 1921 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Dec 24 21

20 UNDERTAKER George J. Smith ADDRESS 6000 Reisterstown

CAUSE OF DEATH in plain terms, so that any person may understand it. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59604

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59604

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1104 Argyle (St.) 17 (Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Warren Carroll

(a) RESIDENCE. No. 1104 Argyle St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced, HUSBAND of, (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 29-21

7 AGE: Years — Months: 6 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS:

10 NAME OF FATHER: Harry L. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Julia Hovey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harry L. Carroll

(Address): 1104 Argyle Ave

15 Filed: DEC 24 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/22 1921

17

I HEREBY CERTIFY, That I attended deceased from 12/10 1921 to 12/22 1921.

that I last saw h alive on 12/22 1921.

And that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Butler, M. D.

, 19 (Address) 2119 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: DEC 24 1921

20 UNDERTAKER: Geo H Holland

ADDRESS 1631 Lemmon Ave

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be understood by the public. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59605

CERTIFICATE OF DEATH.

170-091 59605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 E. 20. St. ST. 17 WARD)

2-FULL NAME Frances Smith

(a) RESIDENCE NO. 114 E. 20. St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5. 1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
82	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co. Md

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catharine Cuird

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ritta F. Hammond

(Address) 114 E. 20th St.

15 Filed . 19 Robert F. [illegible] Registrar

DEC 24 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22. 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16 - 1921. to Dec. 22 - 1921. that I last saw h- alive on dec. 21 - 1921, and that death occurred, on the date stated above, at 4:30 A. m. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cystitis Pelvonic - chronic Interstitial nephritis (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Edward Mason, M. D.

. 19 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Dec 24 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 N. Fayette St.

mation should be [illegible] that it may be [illegible]
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 59606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59606

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) 310 Penn St. (ST.) (WARD)

2-FULL NAME Edna Louise Kollock

(a) RESIDENCE. NO. 310 Penn St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime If U. S. of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Nich. Kollock

6 DATE OF BIRTH (month, day, and year): July 19-1900

7 AGE: Years 20. Months 10 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home duties
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS
10 NAME OF FATHER: Wm Brandt
11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va.
12 MAIDEN NAME OF MOTHER: Danich
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Wm Brandt 310 Penn St

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Dec 23 1921, that I last saw her alive on Dec 23 1921 and that death occurred, on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. G. Fillinger M.D.
12-23-21 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leakin Park Cemetery — DATE OF BURIAL: Dec 26 1921

20 UNDERTAKER: Geo Leinbach & Son — ADDRESS: 6474 Frankford Ave

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

(Keemer)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59607

D 59607

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Hanover ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Randolph Keemer

(Residence in Baltimore: No. 713 Hanover St. St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 28, 1871.
(Month) (Day) (Year)

7-AGE, 50 yrs. — mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Sarah Keemer

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Keemer

(Address) 713 Hanover St

15-

Filed....., 191.....
Registrar.

Robert P. Barrison,

DEC 24 1921 Burial Permit Clerk.

CAUSE OF DEATH to be plain and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1921, to Dec 20 1921, that I saw him alive on Dec 20 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

a
Pulmonary Tuberculosis
b
Duration Unknown
(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Not Known
(Duration)....yrs....mos....ds.

(Signed) W. L. Smith M. D.

Dec 22, 1921. (Address) 129 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Dec 24 1921.

20-UNDERTAKER Clement Hall

ADDRESS 909 Hilen St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59608

92

D 59608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 417-E-Biddle-Street. St.: 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miriam Amelia Herbst.

(a) RESIDENCE. No. 417-E-Biddle-Street. St., 10 Ward. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 48 yrs. 4 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	(Single)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) August-12-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Glen Rock, Penna. (Penna)

PARENTS

10 NAME OF FATHER: William H. Herbst.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Glen Rock Penna.

12 MAIDEN NAME OF MOTHER: Mary M. Grove

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Glen Rock Penna.

14 Informant: Wm. H. Herbst, (father)
(Address): 417-E-Biddle-St., City.

15 Filed . 19 Registrar

24 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-23-1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Dec 23, 1921, that I last saw her alive on Dec 23, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. H. Potter. M. D.

. 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY.	DEC-27-21
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59609

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2415 W. North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Christopher Seabold

(Residence in Baltimore: No. 2415 W. North Ave St.; ... yrs., ... mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	

6-DATE OF BIRTH, Dec (Month) 23 (Day), 1921 (Year).

7-AGE, ... yrs. ... mos. 8 ds. If LESS than 1 day, 8 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), 2415 W. North Ave

PARENTS.

10-NAME OF FATHER, Edward J. Seabold.

11-BIRTHPLACE OF FATHER (State or Country). Balto Md,

12-MAIDEN NAME OF MOTHER Dorothy Jarvis

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. J. Seabold

(Address) 2415 W. North Ave

15-

Filed ..., 191...

Robert P. Harrison, Registrar.

DEC 24 1921 Burial Permit Clerk.

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1921, to Dec 23 1921, that I saw her alive on Dec 23 1921, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas A. Schaup M. D.

Dec 24, 1921. (Address) 53 S. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, Dec 24, 191...

20-UNDERTAKER A. B. Stuppard ADDRESS 2236 Eutaw Pl

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59610

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3707 Claremont St.; 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Meienschein

(a) RESIDENCE. NO. 3707 Claremont ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? 44 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write this word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary Meienschein

6 DATE OF BIRTH (month, day, and year) Nov 13-61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Meienschein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Meienschein (Address) 3707 Claremont St

15 Filed Robert F. Harrison, Registrar

C 24 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1921

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1921, to Dec 22, 1921

that I last saw h alive on ....., 19..

and that death occurred, on the date stated above, at 10:35 P. m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(duration) X yrs. X mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 2 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Jas. L. Finney, M. D.

Dec 24 21 (Address) 2480 3d St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Dec 26 1921
20 UNDERTAKER Philip Herwig	ADDRESS 246 Orleans

CAUSE OF DEATH in plain terms, so that a Coroner can understand it. Do not use abbreviations or initials. Read carefully the rules on back of certificates. TION is very important. See instructions on back of certificates.

D 59611

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59611

REGISTERED No. C 4356

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2010 N North ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Sutton

(Residence in Baltimore: No. 2010 W. North ave St.; 75 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept 22, 1846 (Month) (Day) (Year)

7-AGE: 75 yrs. 3 mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Robert Sutton

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Mary Ann Murray

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W J Tucker

(Address) 2010 W North ave

15 [illegible] Robert F. Harrison, 191

Special Permit Clerk. REGISTRAR

C 24 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. 23, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1912, to Dec. 23 1921.

that I saw h[illegible] alive on Dec. 22, 1921,

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of L Breast

about 9 yrs. (Duration) 9 yrs. — mos. — ds

Contributory (SECONDARY) Exhaustion (Duration) yrs. mos. ds.

(Signed) J. Burd Joyce M. D.

Dec 23, 1921. (Address) 1000 North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Green Mount

DATE OF BURIAL: Dec 25 1921

20-UNDERTAKER: H M Rowton

ADDRESS: 2238 N Howard ave

N. B.-Every item of information should be carefully supplied. Exact statements may be properly classified. Exact statements should be made, so that it may be properly classified. Exact statements should be made, so that it may be properly classified. Exact statements should be made, so that it

D 59612 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59612

CERTIFICATE OF DEATH.

REGISTERED No. C 81

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St Paul & Madison ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frederick Snyder

(Residence in Baltimore: No. 1401 Belt St.; yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE. 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Deshman

(Address) 1403 Belt St.

15- Filed ....., 191.... Registrar. Robert F. Harrison, Burial Permit Clerk.

N.B.—Every item of information must be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August ..... (Month) ..... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ruptured Appendix Peritonitis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

August 22, 1921 (Address) 1039 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, 8/24, 1921

20-UNDERTAKER E. J. Fanning

ADDRESS 1938 Fayette

Coroner has not the slightest idea whether luetic.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia.*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Blks.

D 59613

HEALTH DEPARTMENT—CITY OF BALTIMORE

37

D 59613

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PHS Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Renze Moore

(a) RESIDENCE NO. US. PHS Hosp. #56 Ft McHenry St Baltimore WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	23 yrs.	-	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ------

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George M. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrook Registrar
(Address) US. PHS Hosp. #56 Balto. Md.

15 Filed DEC 24 1921, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 19 21 to Dec 21, 19 21.

that I last saw him alive on Dec. 21, 19 21,

and that death occurred, on the date stated above, at 1 a.m. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmnary far adv. & active

Dec 14/21 (duration) yrs. mos --- ds.

CONTRIBUTORY (Secondary) ------ Syphilis general

--- (duration) -- yrs. - mos --- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

12/21 1921 (Address) US. PHS Hosp. #56 Relay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Dec 24 1921

20 UNDERTAKER John W Henderson

ADDRESS 1502 Fremont

CAUSE OF DEATH in plain terms, so that it may be understood by clerks of registration districts. See instructions on back of certificates. TION is very important.

D 59614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59614

CERTIFICATE OF DEATH.

001

175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital St.; WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Doe

(Residence in Baltimore: No. 1424 E. Madison St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH,

....., 1.....
(Month) (Day) (Year)

7-AGE, 15 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Jones

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Annie Barnes

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Jones

(Address) 1424 Madison st

15- Robert P. Harrison,

Filed DEC 24 1921, 191.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inq
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Traumatism Head

Expts. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Jones M. D.
(Coroner)

12-22-1921 (Address) 9 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Laurel

DATE OF BURIAL, Dec 24, 1921

20-UNDERTAKER John W Henderson

ADDRESS 1302 E Monument

DEC 24 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 59615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59615

CERTIFICATE OF DEATH.

REGISTERED No. C 9/1

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 7 S Dallas St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas Bonner

(Residence in Baltimore: No. 7 S Dallas St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Negro	Single

6-DATE OF BIRTH, (Month) Aug (Day) 11, (Year) 1851

7-AGE, yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Boy
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Earl Howard Bonner

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Minnie Duffy

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Bonner

(Address) 7 S Dallas St

15-

Filed DEC 24 1921, 191.... Registrar.

Burial Permit Clerk

N.B.—Every item of information should be given in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Dec (Day) 22, (Year) 1921

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Shaw Smith M. D.
(Coroner)

Dec 24, 1921 (Address) 1504 Rhode St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Dec 25, 1921

20-UNDERTAKER John W Henderson & Son

ADDRESS 1502

D 59616

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59616

REGISTERED No. C 45 4

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 409 Hubridge Av St.) 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank L. Mastrum

(Residence in Baltimore: No. 409 Hubridge Av St.; 44 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Sept 22 (Month) (Day), 1862 (Year)

7-AGE: 58 yrs. 3 mos. 1 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Watchman for
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Sweden

PARENTS

10-NAME OF FATHER: [illegible] Mastrum

11-BIRTHPLACE OF FATHER (State or country): Sweden

12-MAIDEN NAME OF MOTHER: [illegible]

13-BIRTHPLACE OF MOTHER (State or country): Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E Mastrum

(Address) 322 E. Lafayette

15- Filed DEC 2 1921, 191 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 2 years ago, 191, to, Dec 23 191 21, that I saw h[illegible] alive on Dec 22 191, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

Contributory (SECONDARY) Debility

(Duration) yrs mos ds. In attendance about 2 yrs

(Signed) [illegible] M. D.

Dec 24, 1921 [Address] 1631 E. Lanvale St

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer DATE OF BURIAL: Dec 26, 1921

20-UNDERTAKER: Harry A. Witzke ADDRESS: 1531 W. Lanvale

N.B.—Every item must be filled out in plain terms, so that state CAUSE OF DEATH in plain terms. So that TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59617

D 59617

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S. Third St. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Matilda Laughlint

(a) RESIDENCE. NO. 710 S Third St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of Martin Laughlint.

6 DATE OF BIRTH (month, day, and year) March 29-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER August Bluel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Martin Laughlint.
(Address) 710 S. Third Street.

15 Date Received DEC 24 1921, 19

Robert [illegible]
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 26th 21. to Dec 22 1921.

that I last saw h alive on Aug 26th. 1921.

and that death occurred, on the date stated above, at 7.35 A. m.

The CAUSE OF DEATH* was as follows:

Iron Disease Mitral Valve

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Dropsy (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

[illegible] M. D.
(Signed)
Dec 23. 1921 (Address) 1501 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Dec. 26 1921

ADDRESS 403 S. Broadway

20 UNDERTAKER Lilly & Zeiler.

CAUSE OF DEATH in plain terms. Do not use abbreviations or technical words. Read carefully the inquiries on back of certificates. TION is very important. See instructions on back

EC 24 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59618

CERTIFICATE OF DEATH.

D 59618

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 E. Thirteenth St. ST.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Hund.

(a) RESIDENCE. No. 328 E. Third St. ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22-1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md.

PARENTS

10 NAME OF FATHER John P. Hund.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Mary Lenthank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ellicott City Md

14 Informant John P. Hund.
(Address) 328 E. Thirteenth St

15 Filed DEC 24 1921, 19 Robert F. Harrison. Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1921, to Dec 23, 1921, that I last saw him alive on Dec 22, 1921, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm McCaw, M. D.

(Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Dec 27 1921
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 N. Gay St

CAUSE OF DEATH in plain terms, as directed on back of certificates. See instructions. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59619

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE NO. 315 S. Twelfth ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Hartman.

(a) RESIDENCE NO. 315 S Twelfth ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Jos. Hartman

6 DATE OF BIRTH (month, day, and year) Oct. 5th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Beyer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H. Rodney.
(Address) 130 S. Ellwood Ave.

15 Filed DEC 24 1921, 19 Robert F. Harrison, Registrar
Assistant Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1921, to Dec 23, 1921, that I last saw her alive on Dec 22, 1921, and that death occurred, on the date stated above, at 9 20 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm H. McAvoy, M. D.

Dec 24 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Dec. 27 1921

20 UNDERTAKER Lilly + Zeiler

ADDRESS 403 S. Wolfe St

(Fill in all items in plain terms, so that the CAUSE OF DEATH is very important. See instructions on back of certificates.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59620

83

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4615 Eastern Ave ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Barbara Reher.

(a) RESIDENCE. NO. 4615 Eastern Ave ST., 76 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Reher.

6 DATE OF BIRTH (month, day, and year) Sept. 27-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Frank Dodl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Blumberger.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Reher. 4615 Eastern Ave.

15 Filed ..... 19 ..... Registrar

Robert E. Harrison.

Dec 24 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1921, to Dec 22, 1921, that I last saw h[illegible] alive on Dec 22nd 1921, and that death occurred, on the date stated above, at 12:45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Phlebitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. J. McAvoy, M. D.

Dec 24 1921 (Address) 839 S. Edwards

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 26 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms. [illegible] on back of certificate. TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59621 D 59621 64 D 59621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 N. Mount ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Evans

(a) RESIDENCE. NO. 501 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Annie Evans

6 DATE OF BIRTH (month, day, and year) Feb. 15- 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor

(c) Name of employer Employed by different people

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER John W. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md.

12 MAIDEN NAME OF MOTHER Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co Md.

14 Informant Lottie Brown
(Address) 501 N. Mount St.

DEC 25 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19- 1921, to Dec. 20 1921, that I last saw him alive on Dec. 20 1921, and that death occurred, on the date stated above, at 5-45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 906 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Dec. 25 1921
20 UNDERTAKER	ADDRESS
Fitz B Byrn	102 E. Madison St

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

596222 D 59622

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 596222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 Bryand ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson

(a) RESIDENCE NO. 1217 Bryand ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe | 4 COLOR OR RACE Col. | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Johnson

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE: Years 58 | Months | Days | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Genl Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wilson Stubbs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fanny Stubbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Richard Johnson

(Address) 1217 Bryand St

15 DEC 25 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1921, to Dec 23, 1921, that I last saw h[illegible] alive on Dec 23, 1921, and that death occurred, on the date stated above, at 8 Pm.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Garland Thomas M. D.

(Address) 1534 Druid Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Amity

DATE OF BURIAL Dec 25 1921

20 UNDERTAKER Felix B. Pyz

ADDRESS 1022 Mulberry St

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 59623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Blum

(a) RESIDENCE. No. 1912 E. Lombard St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Golbert Long

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Date DEC 25 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1921

17

I HEREBY CERTIFY, That I attended deceased from December 21, 19 21, to December 24, 19 21, that I last saw her alive on December 23, 19 21, and that death occurred, on the date stated above, at 3:00 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) L. W. Scoadup, M. D.

12/24/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Holy Redeemer	Dec 28 19
20 UNDERTAKER	ADDRESS
Wendell Heppd & Son	37 South

CAUSE OF DEATH in plain terms, so that it may be understood by the laity, or by boards of health, or by boards of examiners of certificates. See instructions on back of certificates. THIS is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59624

CERTIFICATE OF DEATH.

28 D 59624

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 McCulloh ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Meeks

(a) RESIDENCE NO. 911 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John Meeks

6 DATE OF BIRTH (month, day, and year) —— 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home.

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Anne's Co
(State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Bowser

11 BIRTHPLACE OF FATHER (city or town) Queen Ans Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Stewart

13 BIRTHPLACE OF MOTHER (city or town) Queen's Co
(State or country) Md

14 Informant Oneita Blue
(Address) 911 McCulloh St

15 Filed. DEC 23 1921 19 Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Dec, 23rd 1921.
that I last saw h alive on Dec 22d, 1921
and that death occurred, on the date stated above, at 6 15 AM.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Orthopnea
(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Pulm. Tb.
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 771 Forrest St
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Artie Ellis, M. D.
12/23. 1921 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fre Pt. Queen Anne's Co. Md	12/26 1921
20 UNDERTAKER	ADDRESS
Jas. In. Skinner	1620 E. Mad. St

matter should be entered in the CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21 M&T 1500 Bks.

D 59625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 59625

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 N. High St ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Silberman

(a) RESIDENCE NO. 23 N High St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 0 mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcus Silberman

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Balto St

15 Filed DEC 25 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23 1921, to Dec. 24 1921, that I last saw her alive on Dec. 24 1921, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. V. Kaufman, M. D.

12/25 1921 (Address) 1575 N. Bentalou St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	12/26 1921

20 UNDERTAKER Jack Lewis 1411 E Balto St ADDRESS

CAUSE OF DEATH in plain terms, so that any person can understand it. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 59626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59626

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 E. Lombard ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Bloom

(a) RESIDENCE NO. 1016 E. Lombard ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Bloom — 1844

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1411 E. Baltimore St

15 Filed DEC 25 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1921, to Dec. 23, 1921, that I last saw h... alive on Dec. 23, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Stokes Adams Disease

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Hypertension, arterio-sclerosis (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 12/25 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E. Baltimore St

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59627

CERTIFICATE OF DEATH.

91 D 59627

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 N. Harford Road ST., Hamilton WARD)

2-FULL NAME Stanley E. Ashley

(a) RESIDENCE No. 25 N. Harford Road ST. Hamilton WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 10th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas S. Stanley

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Clara M. Yarnaccer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Thomas S. Stanley
(Address) 25 N. Harford Road Hamilton

15 Filed DEC 25 1921 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1921, to Dec 23, 1921, that I last saw him alive on Dec 23, 1921, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stanley E. Ashley M. D.

Dec 24, 1921 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pinewood Cemetery — DATE OF BURIAL: Dec. 26 1921

20 UNDERTAKER: Frank Lecompte Sons — ADDRESS: Baltimore, Md.

CAUSE OF DEATH in plain terms, so that a correct classification may be made. See instructions on back of certificates. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59628 — 17—004 — D 59628

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia M Fouch

(Residence in Baltimore: No. 219½ E. Hoch Ave. St.; yrs. 21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6-DATE OF BIRTH, (Month) Feb (Day) 6 (Year) 1869

7-AGE, 52 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Hosp

9-BIRTHPLACE, (State or Country): Canada

PARENTS.

10-NAME OF FATHER, Thomas P. Fouch

11-BIRTHPLACE OF FATHER (State or Country), Ireland Canada

12-MAIDEN NAME OF MOTHER, Jane M. McLean

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Fouch

(Address) 310 W. 88th St. N.Y.

15- DEC 25 1921 Filed ..... 1921 Registrar

CAUSE OF DEATH in plain terms. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, DEC (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull accident. 2 hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY, (Secondary) Shock

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) C. E. Peaks M. D. (Coroner)

DEC 24 1921 (Address) 43 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ottawa Ontario DATE OF BURIAL, Dec 26, 1921

20-UNDERTAKER John Mitchell ADDRESS 1201 N. Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59629

CERTIFICATE OF DEATH.

1270 D 59629

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. Municipal Hosp. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Baker

(a) RESIDENCE NO. 633 N Paca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Anthony

6 DATE OF BIRTH (month, day, and year): Unknown, 1885

7 AGE — Years: 33 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: M. Kinley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hosp. Records

15 Filed DEC 25 1921 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-22 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Dec 22, 1921, that I last saw h[illegible] alive on Dec 21, 1921, and that death occurred, on the date stated above, at 12 mid.

The CAUSE OF DEATH* was as follows:

Chronic mypocolitis
Chronic syphilis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Myocarditis~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

(Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pat Cemetery — DATE OF BURIAL: Dec 25 1921

20 UNDERTAKER: Paul B Stanley — ADDRESS 178 N Bdle

TION is very important. See instructions on back of c[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59630

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-036 59630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 701 W. Lafayette ave St. 17 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerredine Johnson

(a) RESIDENCE. No. 701 W. Lafayette ave St., ... Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Henson Jerome Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edna May Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edna May Johnson
(Address) 701 W Lafayette ave.

15 Filed DEC 25 1921 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CAUSE OF DEATH In plain terms. Do not use abbreviations or initials. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 24, 1921, that I last saw her alive on Dec 23, 1921, and that death occurred, on the date stated above, at 2.25 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical.

(Signed) William H. Wright, M. D.

Dec 24, 1921 (Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Auburn, Lawn — Dec 26 1921

20 UNDERTAKER — ADDRESS

Samuel Wensley — Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No lues. No further history

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59631

CERTIFICATE OF DEATH.

D 59631

170

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1060 Greenwood Lane St. 27 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bell

(a) RESIDENCE. No. 1060 Greenwood Lane St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced (or) WIFE of Louis Bell

6 DATE OF BIRTH (month, day, and year) Unknown 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlottsville Va

PARENTS

10 NAME OF FATHER Harrison Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dollie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lewis Bell

(Address) 1060 Greenwood Lane

15 Filed DEC 25 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1921, to Dec 23rd, 1921, that I last saw h.. alive on Dec 23rd, 1921, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) High Blood Pressure. Diabetes Kidney Trouble, Senile Decay (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) T. S. Miller, M. D.

12/24 1921 (Address) 1529 Mount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dove Hill Balto Co Md	Dec 25 1921

20 UNDERTAKER Samuel F. Greenberg ADDRESS 578 W Fayette

CAUSE OF DEATH in plain terms, so that it may be understood. See back of certificates. TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Interstitial Nephritis. Primary Phy. does not think patient has lues

Spec.—8-24-14—M. & T.—2000 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59632

D 59632

CERTIFICATE OF DEATH.

109

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 Druid Hill Ave ST.; 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Harris

(Residence in Baltimore: No. 919 Druid Hill Ave St.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, September (Month) (Day), 1839 (Year)

7-AGE, 82 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Chew

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachel Chew

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Chew

(Address) 919 Druid Hill Ave

15- DEC 25 1921 Filed, 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 21 1921, to Dec 22 1921, that I saw h[er] alive on Dec 22, 1921, and that death occurred, on the date stated above, at 2:10 p m.

The CAUSE OF DEATH* was as follows:

Obstruction of small gut

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H Boutsell M. D.

Dec 25, 1921 (Address) 3 E Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Dec 28, 1921

20-UNDERTAKER Samuel Handley ADDRESS 575 W Baltimore St

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59633

CERTIFICATE OF DEATH.

18 ✓ D 59633

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Chauncy Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Dunn

(a) RESIDENCE. No. 805 Chauncy Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown Dunn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) [illegible]

15 Filed DEC 26 1921 19 Registrar

ROBERT P. KRAUSER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1921, to Dec 24th, 1921, that I last saw h[illegible] alive on Dec 24th, 1921, and that death occurred, on the date stated above, at 10.30 p m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Emphysema of the face

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) G. T. Ellis, M. D.

Dec 26, 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holmes Brothers Inc.	12-25 1921

20 UNDERTAKER Jack Lynch ADDRESS 1414 E. Baltimore

CAUSE OF DEATH in plain terms. No abbreviations or terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59634

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hurtt

(a) RESIDENCE. No. Unknown St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Halter 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed DEC 25 1921 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1921, to Dec. 22, 1921, that I last saw h im alive on December 22, 1921, and that death occurred, on the date stated above, at 5:30 P.M. a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Lt. Clyde McNeill

(Signed) , M. D.

12/22/1921 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 12/27 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59635

CERTIFICATE OF DEATH.

64

D 59635

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 700 N. Appleton ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Burdette

(Residence in Baltimore: No. 700 N. Appleton St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH. about (Month) (Day), 1847 (Year)

7-AGE. about 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work: retired (b) General nature of industry, business, or establishment in which employed (or employer): farmer

9-BIRTHPLACE. (State or Country). Md

PARENTS

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs T. Engler

(Address) 700 N. Appleton

15- Filed DEC 25 1921 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CAUSE OF DEATH. In filling out this part, every item is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D. (Coroner.)

Dec. 24, 1921 (Address) 2 N. Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Maryland

DATE OF BURIAL. 12/26 1921

20-UNDERTAKER. William Cook

ADDRESS. 502 E North St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59636

CERTIFICATE OF DEATH.

64 D 59636

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 N. Rose ST.; 8 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Schlegh

(Residence in Baltimore: No. 1407 N Rose St St.; 84 yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, 12 (Month) 24 (Day), 1837 (Year)

7-AGE, 83 yrs. 11 mos. .... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER John Friday

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Schlegh

(Address) 2502 Jefferson

15- Filed DEC 25 1921, 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 24. (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1921, to Dec 23 1921, that I saw her alive on Dec 23 1921, and that death occurred, on the date stated above, at 7.35 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

.... (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

.... (Duration) .... yrs. .... mos. 7 .... ds.

(Signed) F. C. Hesser M. D.

Dec. 24., 1921. (Address) 13 D I N. Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, 12/27, 1921.

20-UNDERTAKER William Cook — ADDRESS 502 E Nor St

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59637

64

CERTIFICATE OF DEATH.

D 59637

1. PLACE OF DEATH

CITY OF BALTIMORE. (No. 4045 Park Hts Ave St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Cornelia L. Disney

(a) RESIDENCE NO. 4045 Park Hts Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ (or) WIFE of Henry R. Disney

6 DATE OF BIRTH (month, day, and year) July 13-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Jos. A Judown

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Sarah Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Ethel Disney (Address) 4045 Park Hts Ave

15 DEC 25 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921, to Dec 23, 1921, that I last saw h[illegible] alive on Dec 23, 1921, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Geo. Young M. D.

, 19 (Address) 1411 Lexington Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Dec 27 1921

20 UNDERTAKER M. E. Cushwa & Son ADDRESS Nath Ave

BEFORE WRITING, see that it may be properly copied. Write CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59638

CERTIFICATE OF DEATH.

150 D 59638

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St Joseph Hospital (St.) 9 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE. No. 607 E 30th St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1/2 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Madge Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

11 Informant Robert Brown

(Address) 607 E. 30th St

DEC 25 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24/1921

17 I HEREBY CERTIFY, That I attended deceased from 12/24/21, 19..., to 12/24/, 19 21, that I last saw her alive on 12/24/, 19 21, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus
Spina Bifida

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C C. Smith, M. D.

, 19 (Address) 4706 Hanford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 26- 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Guilford Ave

CAUSE OF DEATH in plain terms. So that it may be classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59639 D 59639

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 E Hill St ST.: 22 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John M. Ruppert

(a) RESIDENCE. (Usual place of abode) No. 20 E Hill St ST., 22 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced, (or) WIFE of Maggie Ruppert

6 DATE OF BIRTH (month, day, and year) June 16 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Ruppert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rhoda Larson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. J. Ruppert

(Address) 20 E Hill St

Date DEC 25 1921

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 20 1921, to Dec 22 1921, that I last saw h[im] alive on Dec 22 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. Hammond Lee, M. D.

Dec 24 1921 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Dec 26 1924
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59640

CERTIFICATE OF DEATH.

D 59640

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 903 N. Castle ST.: 7 WARD)

2-FULL NAME Minnie Klipner —

(a) RESIDENCE. NO. 903 N Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5 - 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Klipner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ellie Novotny

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Frank Klipner
(Address) 903 N Castle

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1921, to Dec 24 1921,
that I last saw h[er] alive on Dec 25 1921,
and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Volvulus Heart Trouble

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rapert M. D.

12/25/21 (Address) 84 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet

DATE OF BURIAL: 12/27 1921

20 UNDERTAKER: Williams Cook

ADDRESS: 502 N Mt

CAUSE OF DEATH in plain words. Do not use abbreviations or initials. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59641

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 N Montford ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Geweecke (If under 1 day, hrs. min. mos. da.)

(Residence in Baltimore: No. 1709 N Montford ave

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec (Month) 31 (Day), 1856 (Year)

7-AGE, 65 yrs. 11 mos. da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work At Home (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Paul Kromer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Hurell

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas H. Geweecke

(Address) 1709 N Montford ave

15- DEC 26 1921 ROBERT R. KRAUSER, Burial Permit Clerk.

Filed....., 191.... Registrar.

important. See instructions on back of Certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1921, to Dec 25 1921, that I saw her alive on Dec 25 1921, and that death occurred, on the date stated above, at 9 1/2 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis

(Duration) ....yrs. ....mos. 9 ....da.

CONTRIBUTORY (Secondary) Senile

(Duration) ....yrs. ....mos. 2 ....da.

(Signed) Alb A Bogle M. D.

12/25/21 191... (Address) 704 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem

DATE OF BURIAL, Dec 28.., 1921

20-UNDERTAKER Wm Cook

ADDRESS No 26 North Av

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59642

CERTIFICATE OF DEATH.

69

D 59642

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2709 West North ST., 15 WARD)

2-FULL NAME Kate 716- Adler

(a) RESIDENCE NO. 2709 W- North ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred M. Adler

6 DATE OF BIRTH (month, day, and year) Oct. 15- 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John J. Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Athena Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Alfred M. Adler

(Address) 2709 W. North Ave

15 Filed DEC 26 1921 Registrar

ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1921, to Dec. 24th, 1921, that I last saw her alive on Dec. 24th, 1921 and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(duration) 1 yrs. — mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Isaac L. Dickson, M. D.

, 19 (Address) 3055 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	12/29 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E. North

CAUSE OF DEATH to plain terms. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59643

CERTIFICATE OF DEATH.

50 D 59643

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1-1 Esplanade Apt 13 (WARD)

2-FULL NAME August F. Leidenroth

(a) RESIDENCE No. 1-1 Esplanade Apt WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Leidenroth

6 DATE OF BIRTH (month, day, and year) Dec 1/1857

7 AGE — Years: 64 — Months: — Days: — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ditto

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Christian Leidenroth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Eyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary E Leidenroth (Address) 1-1 Esplanade Apt

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

1938 Linden Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1921, to Dec 24, 1921, that I last saw him alive on Dec 23rd, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

several (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual Tests

(Signed) F W Keown M. D.

Dec 25, 1921 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Dec 27 1921

20 UNDERTAKER: William Cat — ADDRESS: 502 E Nat Av

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59644 ✓ 109 D 59644

CERTIFICATE OF DEATH.

D 59644

REGISTERED NO. .....

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Rebecca Senft

(a) RESIDENCE NO. Littlestown Pa. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Harry A Senft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Martha E Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Harry A Senft
(Address) Littlestown Pa

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to Dec 26, 1921, that I last saw h[illegible] alive on Dec 26, 1921, and that death occurred, on the date stated above, at 1 00 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Unknown.
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 24, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Operative findings

(Signed) S E Duncan M. D.

12/26, 1921 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Luke's Littletown	12/28 1921
20 UNDERTAKER	ADDRESS
W J Fahrney & Sons	Littlestown Pa

Make the information on this side of CERTIFICATE OF DEATH in plain terms, so that it may be understood by others than physicians. Write the CAUSE OF DEATH in plain terms, so that it may be understood by others than physicians. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59645

CERTIFICATE OF DEATH.

120

REGISTERED NO. D 59645

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 W. Fort Ave. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Becker.

(a) RESIDENCE NO. 113 W. Fort Ave ST., 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Becker.

6 DATE OF BIRTH (month, day, and year) Oct 5th. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	66	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Christian Bowers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Johanna Hillen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Casper Becker. (son)

(Address) 113 W. Fort Ave.

15 Filed DEC 26 1921 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 19 21.

17

I HEREBY CERTIFY, That I attended deceased from Dec 22nd. , 1921 , to Dec 22nd. , 19 21.

that I last saw her alive on Dec 22nd. , 19 21.

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Aboblexy.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Otto K. Reinhardt M. D.

12/22/21 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Dec. 26 19 21

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1 W Lights St

CAUSE OF DEATH in plain terms, so that it may be understood by the people. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59646

CERTIFICATE OF DEATH.

113 D 59646

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 701 Curtis Ave. ST.: Curtis Bay 25 WARD)

2-FULL NAME. Martha Frances Olsen

(a) RESIDENCE. NO. 701 Curtis Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry P. Olsen

6 DATE OF BIRTH (month, day, and year) Sept 25, 1872

7 AGE: Years 49 | Months 2 | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: John Magruder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Rose O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Enfield, Md.

14 Informant: Harry P. Olsen
(Address): 701 Curtis Ave

15 Filed DEC 26 1921 19.. Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1921, to Dec. 23, 1921, that I last saw h~~e~~r alive on Dec. 22, 1921, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) Geo. B. Davis, M. D.

12/24, 1921 (Address) 211 Church St., Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem Cattle DATE OF BURIAL: Dec. 26 1921

20 UNDERTAKER: Margaret G. Flynn ADDRESS: 1432 Light St.

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. Physicians may use technical terms in addition to, but not instead of, plain terms. Do not write on back of certificates. TION is very important. See instructions on back.

D 59647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 59647

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Ave Falls Station (P.O.) ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Edward

(Residence in Baltimore: No. 2128 S. Charles St

12 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	colored	Married

6-DATE OF BIRTH July 7, (Month) (Day) 1877 (Year)

7-AGE, 45 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Factory
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.H.

9-BIRTHPLACE. (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Wm Edwards

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Minnie Jenkins

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Edwards

(Address) 2125 S. Charles St.

15 DEC 26 1921 Filed....., 191..... ROBERT R. KRAUER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Morris M. D.
(Coroner.)

Dec 26, 191.. (Address) 2613 Guilford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Dec 26, 1921.

20-UNDERTAKER Wm J. Edwards ADDRESS 1425 S. Charles St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59648

152

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene ST.) W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Clara Zimmerman

(a) RESIDENCE. NO. 2229 Ruskin Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (CD)

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Leo A. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Emily M. Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md

14 Informant (Address) Leo. A Zimmerman 2229 Ruskin ave

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CAUSE OF DEATH in plain terms. Do not use abbreviations or terms of doubtful meaning. Any cause of death which may be the result of violence must be fully explained. See instructions on back of certificate. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1921, to Dec 24, 1921, that I last saw her alive on Dec 24, 1921, and that death occurred, on the date stated above, at 430 P m.

The CAUSE OF DEATH* was as follows:

Spontaneous Hemorrhage of newborn

(duration) ..... yrs. mos. 5 ds.

CONTRIBUTORY: Intracranial Pressure

(Secondary) Cerebral Hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

12-24 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 26 1921
20 UNDERTAKER	ADDRESS 916
David Carter	Saint

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59649

CERTIFICATE OF DEATH.

64 V

REGISTERED No. D 59649

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Halbrook ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbus W. Wilson

(a) RESIDENCE No. 1726 Halbrook ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, ~~or Divorced,~~ (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mary E. Wilson

6 DATE OF BIRTH (month, day, and year) Feb 22nd 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77 Years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 075

(b) General nature of industry, business, or establishment in which employed (or employer) Stone Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Point of Rock Va.

PARENTS

10 NAME OF FATHER James L. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E. Lamman

13 BIRTHPLACE OF MOTHER (city or town) Port Deposit (State or country) Cecil County

14 Informant John W. Wilson

(Address) 1726 Halbrook ave

15 Filed DEC 26 1921 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to Dec 23, 1921, that I last saw h~~e~~r alive on Dec 22, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Coal Yard Transport Edgewood

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) James Adams M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 27 1921
20 UNDERTAKER	ADDRESS
Geo. F. Ruth	1735 Hanford Ave.

CAUSE OF DEATH in plain terms, so that it may be used for statistical purposes. See instructions on back of certificates. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 ✓

D 59650

REGISTERED NO.

D 59650

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1102 Hilcox ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. A. Remmel

(a) RESIDENCE NO. 1102 Hilcox ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Anna C. Remmel

6 DATE OF BIRTH (month, day, and year) June 30 1870

7 AGE: Years 51; Months 5; Days 24; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Receiving Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): at Coors Cattle Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Conrad Remmel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary A. Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Mrs. Anna C. Remmel 1102 Hilcox

15 DEC 26 1921 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1921, to Dec 24 1921,

that I last saw him alive on Dec 24 1921,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Asthma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. McCarter, M. D.

Dec 27, 1921 (Address) 1114 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL Dec. 27 1921

20 UNDERTAKER: Henry Woerle & Son ADDRESS 1301 Eager St

BE SURE CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important

Spec. 26-9-10 H. P. Co.—1000 Blks.

D 59651

D 59651

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2337 McElderry ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Stuart

(a) RESIDENCE. No. 2337 McElderry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Married

6 DATE OF BIRTH (month, day, and year) Feb 17 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector 077

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Holesale Dr Liquor Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Martha Stuart (Address) 2337 McElderry St

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Dec. 22, 1921, that I last saw him alive on " " , 1921, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Army - Probably

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Post mortem made at Hopkins Hospital

(Signed) H. B. Collenberg, M. D.

Dec 24. 1921 (Address) 1810 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 26 1921
20 UNDERTAKER Russ C. Miller	ADDRESS 2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 59652

CERTIFICATE OF DEATH.

78 D 59652

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 5 Carter Ave. Hamilton (17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Gundlach

(a) RESIDENCE NO. 5 Carter Ave. Hamilton ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. 2 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept. 28th 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William F. Gundlach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Northear Harr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: William F. Gundlach

(Address): 5 Carter Ave Hamilton Md.

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Dec 23 1921,

that I last saw him alive on Dec 23 1921,

and that death occurred, on the date stated above, at 11.55 p. m.

The CAUSE OF DEATH* was as follows:

Exhaustion and Tuberculosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Simon, M. D.

Dec 23, 1921 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: Dec. 26th 1921

20 UNDERTAKER: Mr. & Mrs. John H. Tuppl & Son

ADDRESS: 801 W. Fayette

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 59653

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Heaver St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Porter

(a) RESIDENCE. No. 427 Heaver ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Porter

6 DATE OF BIRTH (month, day, and year) Feb 22 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boatblock Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Builder. O Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Andrew Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Jennie Toney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Martha Porter

(Address) 427 Heaver St

15 DEC 26 1921

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Dec 24, 1921, that I last saw him alive on Dec 24, 1921, and that death occurred, on the date stated above, at 6.10 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Rheumatism Chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald L. Town, M. D.

, 19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Washington Lodge Dec 26 1921

20 UNDERTAKER ADDRESS

Samuel W. Lewis Dr. 1165 N

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59654

CERTIFICATE OF DEATH.

640 59654

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 3510 Claremount ST.: 26 WARD)

2-FULL NAME Philip Walter

(a) RESIDENCE NO. 3510 Claremount ST.: 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Lorena Walter

6 DATE OF BIRTH (month, day, and year) Aug 15, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Gov

(c) Name of employer Robinson Co

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lorena Walter (Address) 3510 Claremount

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23' 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1921, to Dec 23 1921, that I last saw h[illegible] alive on Dec 23 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Kleinberg M. D.

, 19 (Address) 1340 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cem

DATE OF BURIAL Dec 27 1921

20 UNDERTAKER Mrs C E Evans

ADDRESS 1425 E Chase St

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Spec. 1-10-21 MAT 1500 Blks.

59655

HEALTH DEPARTMENT—CITY OF BALTIMORE

59655

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 N. Montford Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Bureach

(a) RESIDENCE No. 801 N. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonie Bureach

6 DATE OF BIRTH (month, day, and year) Dec. 24 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Violine maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. K. Eisenbrandt

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Bureach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Gustava

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Antonie Bureach

(Address) 831 N. montford Ave

15 Filed DEC 26 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Dec 24, 1921, that I last saw h[illegible] alive on Dec 24, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Nephritis (Bright's)

Cardiac Changes.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Com. Examination

(Signed) Joseph E. Fichman, M. D.

, 19 (Address) 1576 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 27 1921

20 UNDERTAKER Fielder & Fielder

ADDRESS 1237 E. Eager

CAUSE OF DEATH: All parts should be filled in by the attending physician. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Wollrab

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59656

CERTIFICATE OF DEATH.

100

D 59656

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 N. Central Ave St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME, Edward Wollrab.

(Residence in Baltimore: No. 1219 N. Central ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Sept 22, 1913
(Month) (Day) (Year)

7-AGE, 6 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At school
(b) General nature of industry, business, or establishment in which employed (or employer): ---

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. D. Wollrab

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Delmar K. Seward

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. D. Wollrab

(Address) 1219 N. Central ave

15- DEC 26 1921 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.
Filed ..... 191.....

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22 1921, to Dec. 25 1921, that I saw him alive on Dec. 25 1921, and that death occurred, on the date stated above, at 1:15 p.m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) Half hour

CONTRIBUTORY (Secondary) Acute Follicular tonsilitis

(Duration) ....yrs. ....mos. 4 ds.

(Signed) G. Lakotos Ewalt M. D.

Dec. 25, 1921. (Address) 905 N. Fulton Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec. 27, 1921.

20-UNDERTAKER Fuhrer Fickes — ADDRESS 1734 E. Eager

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59657

CERTIFICATE OF DEATH.

170

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 852. W. Lombard ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie F. Emmerich

(a) RESIDENCE. No. 852. W. Lombard ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — J. Edward Emmerich

6 DATE OF BIRTH (month, day, and year) Jan 12, 1860

7 AGE: Years 61. Months 11 Days 13. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): 001

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John Reynolds.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Susan Wingfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Annie M. Formick

(Address) 852. W Lombard St.

15 Filed DEC 26 1921

ROBERT R. KRESSLER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24/21 19

17 I HEREBY CERTIFY, That I attended deceased from 11/7/21, to 12/24/21, 19....,

that I last saw h.... alive on 12/21, 19....,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int Nephritis

Mitral regurg

uremia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Marsh Tenney, M. D.

12/25, 19.. (Address) 9 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec 28th, 1921
20 UNDERTAKER: John J. Cowan & Son, Chas J. Cowan	ADDRESS: 901 Hollins St

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 59658

D 59658

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N. Wolfe ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Shimanek

(a) RESIDENCE. NO. 911 N. Wolfe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced — (or) WIFE of: John Shimanek

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 52 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Michal Bella

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): John Shimanek 911 N Wolfe St

15 Filed DEC 26 1921 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Dec 24, 1921, that I last saw h[illegible] alive on Dec 24, 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

a Pulmonary Tuberculosis

b

c

d

(duration) 3 mos. ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Reese M. D.

Dec 24 1921 80 W Lanvale

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 27 1921

20 UNDERTAKER: Ernest Brock & Son — ADDRESS 1906 Eastern

CAUSE OF DEATH. The particulars required by this certificate must be obtained from the best available sources. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59659

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 14 WARD)

2-FULL NAME Robert Mayo

(a) RESIDENCE. No. 329 N. Gilmore St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day: hrs. or min.
	63	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER William Mayo

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Georgia Shavers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records, (Address) Municipal Hospital

15 Filed DEC 26 1921 ~~ROBERT H. KRAUTER~~ Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1921, to Dec 23, 1921, that I last saw him alive on Dec. 22, 1921, and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. W. Bradley Jr. M. D.

12/23/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec 26 192

20 UNDERTAKER John H. Tradewell — ADDRESS 143 Hartford St

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 59660

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 W. Lexington St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Wangle

(a) RESIDENCE. NO. 843 W Lexington St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Wh

5 Single, Married, Widowed, or Divorced (write the word) Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-29-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mollie Wangle
(Address) 843 W. Lexington

15 DEC 26 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Dec 25, 1921, that I last saw h alive on Dec 24 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Atheroma Degen Heart and Arteries.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Arrowsmith, M. D.

Dec 26, 1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	12-27 1921
20 UNDERTAKER H. C. Brauningson	ADDRESS 1711 Belvedere St

TION is very important. See instructions on back of certificates.

Spec.—S-2474—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59661

CERTIFICATE OF DEATH.

120 ✓

D 59661

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 N. Fulton Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Turner

(Residence in Baltimore: No. 548 N. Fulton Ave St.; 30 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 12 (Day), 1845 (Year)

7-AGE, 76 yrs. 7 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... At home

9-BIRTHPLACE, (State or Country), Stoneridge, Ulster Co, N.Y.

PARENTS.

10-NAME OF FATHER, Alexander Robinson

11-BIRTHPLACE OF FATHER (State or Country), Ulster Co. N.Y.

12-MAIDEN NAME OF MOTHER Mary Ann Bond.

13-BIRTHPLACE OF MOTHER (State or Country), Ulster Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estelle Littlefield

(Address) 548 N. Fulton Ave

15- Filed DEC 26 1921 '21 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 9th 1921, to Dec 24th 1921, that I saw her alive on Dec 24th 1921, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) — yrs. 4½ mos. — ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) — yrs. — mos. 17 ds.

(Signed) Edw. A. Pearce M. D.

Dec 24th 1921 (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 27, 1921

20-UNDERTAKER Jacob Dyer — ADDRESS 16 W. Wells St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59662

CERTIFICATE OF DEATH.

D 59662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3458 Leeds ST., 20 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Reese

(a) RESIDENCE NO. 3458 Leeds St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Manner

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (40)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Queen Anne Co (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Reese

11 BIRTHPLACE OF FATHER (city or town) Queen (State or country) Anne Co, Md.

12 MAIDEN NAME OF MOTHER Mary Ryans

13 BIRTHPLACE OF MOTHER (city or town) Dueda (State or country) Anne Co-Md

14 Informant William F. Ryans
(Address) 324 Eastmount St

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/1 1921, to 12/24 1921, that I last saw him alive on 12/24 1921, and that death occurred, on the date stated above, at 9.45A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of Pancreas, metastases

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

Carcinomatosis (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical findings

(Signed) Hamrick Mayer M. D.

, 19 (Address) 336 Fredrick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery Catonsville Md	Dec 27 1921

20 UNDERTAKER Edward Wm Yr

ADDRESS 933 Edmondson Ave Catonsville Md.

CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59663

CERTIFICATE OF DEATH.

X 179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Gunnes. Annie

(a) RESIDENCE. NO. 104 Winter Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard County

PARENTS

10 NAME OF FATHER Matthew Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George County

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick County

14 Informant Edward W. Pye.
(Address) Catonsville Md.

15 Filed DEC 2 1921 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1921. to Dec. 25. 1921.
that I last saw her alive on Dec. 25. 1921.
and that death occurred, on the date stated above, at 3 30 p. m.
The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) S W Kennedy, M. D.

, 19 (Address) 623 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cemetery	Dec. 28 1921
20 UNDERTAKER Edward W. Pye.	ADDRESS Edmondson Ave.

Information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is neeessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report speeifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, ete. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operated on for
fibroid tumor uterus
non malignant.
Acute nephritis -
No further history

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59664

D 59664

176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Broadway ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenel Clair

(a) RESIDENCE No. 1037 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie S. Clair

6 DATE OF BIRTH (month, day, and year) Sept. 24th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mc Alisterville Pa.

PARENTS

10 NAME OF FATHER David Clair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret Stray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Grace C. Leach (Address) 1037 N. Broadway

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Burial Permit Clerk. Recorder.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24th 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1921, to Dec 23, 1921, that I last saw him alive on Dec 23, 1921, and that death occurred, on the date stated above, at 3.20 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 16 ds.

CONTRIBUTORY, (Secondary) Prostatetis, retention of Urine (duration) yrs. mos. 54 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) A W Buchanan, M. D.

Dec. 24 1921 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mc Alisterville Pa DATE OF BURIAL Dec 27 1921

20 UNDERTAKER Jos B Cook ADDRESS 1003 N Balto

mation should be carefully supplied. Age, sex, color, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59665

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1078 Sexton ST., (Monrell Park WARD)

2-FULL NAME Catherine Annie Herr

(a) RESIDENCE No. 1078 Sexton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Elizabeth Miller

(Address) 1078 Sexton Ave

15 DEC 27 1921 Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 1 1921 to Dec 25 1921

that I last saw her alive on Dec 25 1921

and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. A. Mitchell M. D.

Dec 26 1921 (Address) Monrell Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 28 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Mayers

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59666

D 59666

10-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 N Mulberry ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Virginia Mayers

(a) RESIDENCE. NO. 1508 N. Mulberry ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Oct 14 - 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Living at home

(b) General nature of industry, business, or establishment in which employed (or employer) 869

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Virginia

PARENTS

10 NAME OF FATHER James B Mullen

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliza Mayhorne

13 BIRTHPLACE OF MOTHER (city or town) Fairfield (State or country) Connecticut

14 Informant Alice S. Parkhurst (Address) 1410 Park Ave

15 DEC 27 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1921, to Dec 26th 1921, that I last saw her alive on Dec 26th 1921, and that death occurred, on the date stated above, at 11.a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. S. Parkhurst M. D.

12/26 1921 (Address) 1410 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Dec 29 1921
20 UNDERTAKER	ADDRESS
J B Cook	1003 E Balto

N. B. ... mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59667

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

D 59667

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3904 Fernwood Ave ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myron Henry Merritt

(a) RESIDENCE. NO. 3904 Fernwood Ave ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 24, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Premature infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Myron Merritt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Katherine D Brinman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant William M. Merritt
(Address) 3904 Fernwood Ave.

15 Filed DEC 27 1921, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Dec 24, 1921, that I last saw h— alive on Dec 24, 1921, and that death occurred, on the date stated above, at 12.25 A m.

The CAUSE OF DEATH* was as follows:

Premature birth at about 7th month of Pregnancy

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) not known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

12/24/1921 (Address) 1014 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Dec 26 1921

20 UNDERTAKER: Lilly and Zieler ADDRESS: 403 S. Wolfe St

mation should be given in plain terms, so that it may be properly entered on the records and a correct transcript of certificates. CAUSE OF DEATH in plain terms, so that it may be properly entered on the records and a correct transcript of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59668

CERTIFICATE OF DEATH.

5 93 D 59668

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 522 N. Central ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Brown

(a) RESIDENCE. No. 522 N. Central ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Estella Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 45 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber ret

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Baltimore Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Estella Brown (wife)
(Address) 522 N Central Ave.

15 Filed DEC 27 1921 19 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/1 1921, to 12/24 1921, that I last saw him alive on 12/24 1921, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Empyema ppd

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) General Septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) R. A. Young, M. D.

, 19 (Address) 1421 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 27 1921
20 UNDERTAKER	ADDRESS
Mrs Thos B. Jones	Garrison Ave

CAUSE OF DEATH in plain terms, as directed on back of certificates. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Tuberculous. Source of infection or cause of septicaemia unknown.

D 59669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59669

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3804 Lloyd Ave ST. 28 WARD) REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas B. Fitzpatrick

(Residence in Baltimore: No. 3804 Lloyd Ave. St.; 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Oct. 26, 1864 (Month) (Day) (Year)

7-AGE, 57 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Master Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): O M

9-BIRTHPLACE, (State or Country), Md,

PARENTS.

10-NAME OF FATHER, Bernard Fitzpatrick

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Cathryn Buckley

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Fitzpatrick

(Address) Harford Co, Md,

15-

Filed DEC 27 1921 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D. (Coroner.)

Dec. 26. 1921 (Address) 2502 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Abingdon Md — DATE OF BURIAL, 12/27 1921.

20-UNDERTAKER Robert Burke Son — ADDRESS Calhoun & Hollins

N. B.—Every item of information called for should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59670

D 59670

CERTIFICATE OF DEATH.

167

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hosp. WARD) 21

2-FULL NAME Mrs. Walter A. Pope

(a) RESIDENCE NO. 2140 Columbia Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Pope

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 940

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) S. C.

PARENTS

10 NAME OF FATHER G. H. Cope

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) S. C.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant Mrs. Evelyn (Cope) (Address) [illegible]

15 DEC 27 1921 ROBERT R. KRAUTER Burial Permit Clerk, Registrar

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 19 21, to Dec 24 19 21.

that I last saw her alive on Dec 24, 19 21

and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH was as follows:

Second degree burn covering face and 3/4 of body (One)

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore Engraving & Novelty Co- Mt. Royal Ave

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. C. Caldwell M. D.

12/24, 1921 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL 12/27 1921

20 UNDERTAKER Robert Brooks & Son ADDRESS Calhoun & Hollins sts

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 59671 D 59671

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 59671 D 59671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) 4 Broadway (St.:) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Wallace

(a) RESIDENCE: No. High Rock Pa St.. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (~~WIFE~~) Maggie B Wallace.

6 DATE OF BIRTH (month, day, and year) Mar. 28, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56		8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER John T. Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Nellie A. Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Maggie B. Wallace. High Rock Pa.

15 Filed DEC 27 1921 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 26 '21 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1921, to Dec 26, 1921, that I last saw him alive on Dec 26, 1921, and that death occurred, on the date stated above, at 2:35 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 12 17 21

Was there an autopsy? Yes - Partial

What test confirmed diagnosis? Microscopic exam. of operation

(Signed) C W Noble, M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hopewell Cemetery York Pa DATE OF BURIAL Dec 30 19

20 UNDERTAKER Harry H Witzke ADDRESS 1531 W. Lombard St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59672

59672

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1640 Clarkson ST.: 72 WARD)

2-FULL NAME Eliza Heidereich

(a) RESIDENCE. NO. 1640 Clarkson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced (or) WIFE of: John P. Heidereich

6 DATE OF BIRTH (month, day, and year): Jan. 16, 1874

7 AGE: Years 47; Months 11; Days 8; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Delaware

PARENTS

10 NAME OF FATHER: Geo. Gladhill

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Eliza Swales

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): John P. Heidereich St. 1640 Clarkson

15 Filed ....., 19..... Registrar

DEC 27 1921 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1921, to Dec 24 1921.

that I last saw h.. alive on Dec 18 1921.

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. P. Hyatt, M. D.

, 19 (Address) 352 Gregory St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem.

DATE OF BURIAL: Dec 27 1921

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St.

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

59673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59673

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jennie Collins

(a) RESIDENCE. NO. Preston & Valley Sts ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widows of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh Collins.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Unknown 74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker. 869

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Matthew McCloskey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence (Address) Little Sisters Poor.

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Record, 19..., to ..., 19..., that I last saw her alive on Dec 25, 1921, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Warner, M. D.

Dec 27, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	12/27/1921

20 UNDERTAKER ADDRESS

H. C. Winfield 914 Fremont

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

S[illegible]—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59674

CERTIFICATE OF DEATH.

64 D 59674

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1114 Wilcox ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Wallace

(a) RESIDENCE. No. 1114 Wilcox ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Wallace

6 DATE OF BIRTH (month, day, and year) Oct 20 [illegible]7

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Michael Wallace
(Address): 1114 Wilcox St

15 Filed DEC 27 1921 19

ROBERT E. KRAUSE Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 [illegible] 1921, to Dec 24, 1921.

that I last saw her alive on Dec 23, 1921.

and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 2 mos' (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Evy

(Signed) W. J. Riley, M. D.

12/26/21 (Address) 1034 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Mary Grave	12/28/21 19

20 UNDERTAKER: A. C. Wiedefeld ADDRESS 914 Gunmore

CAUSE OF DEATH: This line for information concerning the primary cause, secondary (contributory) causes, and duration of each. Indefinite statements such as "Heart Disease," "Cancer," "Tuberculosis," "Senility," "Old Age," "Infirmities of Age," are not sufficient. Write plainly with ink. See instructions on back of certificate. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 59675 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59675

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 S. Charles St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Balla

(a) RESIDENCE. No. 1718 s. Charles St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise M Balla

6 DATE OF BIRTH (month, day, and year) Mar. 25 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER John T. Balla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary F. Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant John T. Balla
(Address) 1537 Hanover St

15 Filed . 19 ROBERT R. KRAUTER, Registrar
DEC 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 . 1924 . to Dec 24 . 1924 . that I last saw him alive on Dec 23 . 1924 . and that death occurred, on the date stated above, at 4.30 A m. The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation "

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Hawkins, M. D.

12/26/1924 (Address) 1 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Dec 27 1924
20 UNDERTAKER	ADDRESS
D. Few McCully	130 E. Fort

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59676

D 59676

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 N. Chester ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. H. Mitchell Sr.

(a) RESIDENCE. NO. 1206 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Sarah E. Levey

6 DATE OF BIRTH (month, day, and year) May 24/51

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thos. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah E. Mitchell
(Address) 1206 N. Chester St.

15 DEC 27 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1921, to Dec 25th, 1921, that I last saw h~~im~~ alive on Dec 25th, 1921, and that death occurred, on the date stated above, at 3 15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alg S Gagl, M. D.

Dec 26/21 (Address) 709 N Bdway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 28 1921
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly coded. MEDICAL CERTIFICATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59677

D 59677

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 618 N. Curley ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schady

(a) RESIDENCE. NO. 618 N Curley ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or, WIFE of) Gustav R. Schady

6 DATE OF BIRTH (month, day, and year) Aug. 15th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown Schady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs. Herman Springer 618 N. Curley St-C

15 Filed DEC 27 1921 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1921, to Dec 24, 1921, that I last saw her alive on Dec 24, 1921, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Hypostatic congestion
of lungs

(duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secundary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Maxwell L Myers M. D.

12/26/21 (Address) 3115 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood cemetery	Dec 28th 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2012 Orleans St

BEFORE SIGNING, READ CAREFULLY. Please see that this certificate is properly and completely filled out, so that it may be permanently recorded. Write plainly and in ink. Use no abbreviations. Do not use ditto marks. Be sure to answer every question in plain terms, so that it may be properly classified. Do not report "Old Age" as CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not report "Old Age" as CAUSE OF DEATH. Indefinite and unsatisfactory returns will be returned for correction. Carefully read the instructions printed on the back of certificates. ATTENTION is very important. See instructions on back of certificates.

Diadamia Baker

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59678

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 N. Warburton St. WARD 8)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Diadamia Baker

(a) RESIDENCE. NO. 1518 N. Warburton St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 17, 1850

7 AGE: Years 71 Months 5 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cleveland Ohio

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs Nolan 1146 N. Washington St

DEC 27 1924 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 25 1924

17 I HEREBY CERTIFY, that I attended deceased from Dec 24 1924 to Dec 25 1924, that I last saw h[illegible] alive on Dec 25 1924, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 24 hr ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Bruce, M. D.

12/26/1924 (Address) 1401 W. Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Dec 28 1924

20 UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT N. KNOTTS
Deputy Health Clerk
Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

Nov 1180

59679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 V D 59679

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Mc Culloh ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stevenson

(a) RESIDENCE No. 1011 N. Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James E. Stevenson

11 BIRTHPLACE OF FATHER (city or town) Crisfield
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Scott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant James E. Stevenson
(Address) 1011 Mc Culloh St

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19th 1921 to Dec 19th 1921, that I last saw h~~e~~ alive on Dec. 19th 1921, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

The Child was born w/o a soul and no one present had time enough to remove it before death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) A. Lee Ellis, M. D.

12/20, 1921 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: John Hopk Hosp.

DATE OF BURIAL 19

20 UNDERTAKER: A Lee Ellis

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59680

CERTIFICATE OF DEATH.

102

D 59680

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Foot Riverview ave, ST.: No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robert Insley

(a) RESIDENCE. No. Foot Riverview ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Helen T. Insley

6 DATE OF BIRTH (month, day, and year) Feb 23 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer) O'S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oliver P Insley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Henning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Andrew Insley
(Address) Dundalk Md.

15 Filed DEC 27 1921 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 23 1921, to Dec 25 1921, that I last saw h. im alive on Dec 25 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer, perforated

over

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Xray

(Signed) Alt. Reier, M. D.

12/21. 1921 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec 28 1921
20 UNDERTAKER	ADDRESS
John Herwig & Co	2008 Orleans

CAUSE OF DEATH must be plainly written. Use ink. Do not use pencil. Fill in all blanks. Make no abbreviations. Physician must sign certificate and state address. Omissions cause delay and expense. Read carefully the instructions on back of certificates. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59681

CERTIFICATE OF DEATH.

64

REGISTERED No. D 59681

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 625 N. Carrollton Ave ST.. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta K Rhodes

(Residence in Baltimore: No. 625 N. Carrollton Ave. St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH. Aug. 29, 1843 (Month) (Day) (Year)

7-AGE. 78 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work. Home duties.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). England

PARENTS.

10-NAME OF FATHER. John Robinson

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER ? Higgins

13-BIRTHPLACE OF MOTHER (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary K Rhodes

(Address) 625 N. Carrollton Ave

15-Filed DEC 27 1921 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. S. Hennessy M. D. (Coroner.)

Dec 26, 1921 (Address) 2803 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western	12-27- 1921
20-UNDERTAKER H. C. Brauning & Son	ADDRESS 517 N. Howard St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 59682 — 50 — D 59682

CERTIFICATE OF DEATH

(PLACE OF DEATH) — REGISTERED NO. C

CITY OF BALTIMORE (No. 405 N. Fulton Ave — ST. — WARD) 20

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Alberta Brantill

(Residence in Baltimore: No. Home for the Aged of the M.E. Church — St.; 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: July 7th, 1842 (Month) (Day) (Year)

7 AGE: 79 yrs. 5 mos. 16 ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Andrew Saulsbury.

11 BIRTHPLACE OF FATHER (State or country): Delaware.

12 MAIDEN NAME OF MOTHER: Mary Ann Adams

13 BIRTHPLACE OF MOTHER (State or country): Baltimore.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta Cuddy Supt.

(Address) 400 N. Fulton Ave.

15 DEC 27 1921 — ROBERT R. KRAUTER — REGISTRAR — Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 26 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1921, to Dec 26 1921 that I saw h[er] alive on Dec 24, 1921 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Insipidus

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Gangrene of heel - due to Diabetes.

(Duration) yrs. 1 mos. ds.

(Signed) George C. Shannon M. D.

Dec 26, 1921. (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Dec 28, 1921

20 UNDERTAKER: George J Smith — ADDRESS: 1000 Fayette St

N.B.-Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 case was diabetes mellitus

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemon*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Solesman*, (*b*) *Grocery*; (*a*) *Foremon*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Washington Road

Spec.—8-24-14—M. & T.—2000 Bks.

D 59683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1078 Druid Hill St.; 17 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Washington Peale

(Residence in Baltimore: No. above 1078 Druid Hill Road St.; 68 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1853 (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hansas Trotter Jr.

(Address) 566 Greenmount Ave

15-

Filed Dec 27 1924 191

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CAUSE OF DEATH must be entered by physician. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11th 1924, to Dec 24 1924, that I saw him alive on Dec 23d 1924, and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

8 Months Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 12 ds.

(Signed) J. D. Abbott M. D.

12.27., 191.. (Address) 211 N. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Lawn

DATE OF BURIAL, Dec 27, 1924

20-UNDERTAKER Edward D. Hemsley

ADDRESS 578 N Eddest

Stock—6-9-19—H. P. Co.—1000 Blks.

59684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1700 59684

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3424 Park Heights Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah R. Cooling.

(a) RESIDENCE. NO. 3424 Park Heights Ave ST.: ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6a ~~M married, widowed, or divorced~~ HUSBAND of (or) WIFE of Samuel H Cooling.

6 DATE OF BIRTH (month, day, and year) Feb 15 1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elias ~~Ruhley~~ Barnaby.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah. Ruhley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant S. Carle Coolidg (Son)

(Address) 3424 Park Heights Ave

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CAUSE OF DEATH in plain language. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 24 21

17

I HEREBY CERTIFY, That I attended deceased from Oct 15 1919, to Dec 24 1921.

that I last saw h alive on Dec 24 1921.

and that death occurred, on the date stated above, at 11.20 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chronic Brights, & Endocarditis

(duration) 4 mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physician

(Signed) J Walter Timms, M. D.

Dec 26, 1921 (Address) 1225 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Havre de Grace Md	12-27 1921
20 UNDERTAKER	ADDRESS
E & B Hale	115 E West St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59685

CERTIFICATE OF DEATH.

64 D 59685

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 Weber ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna C Herr

(a) RESIDENCE. No. 130 Weber ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Henry Herr

6 DATE OF BIRTH (month, day, and year) January 9 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 027

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Jo Wormuth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Catherine Senghert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Henry Herr

(Address) 130 Weber St

15 Filed DEC 27 1921 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to Dec 26, 1921, that I last saw her alive on Dec 25, 1921, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Paralysis of Respiratory Center

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis Apoplexy, Hemiplegia

(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S Tonry, M. D.

, 19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co	12-29 1921
20 UNDERTAKER	ADDRESS
E & B Hale	115 E West St

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59686

CERTIFICATE OF DEATH.

64 D 59686

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1262 Rumsdean ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Zapp

(a) RESIDENCE. No. 1262 Edmondson Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Zapp

6 DATE OF BIRTH (month, day, and year): Aug. 12-1844

7 AGE — Years: 77 Months: 4 Days: 13 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John W. Knell

(Address): 1262 Rumsdean

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1921, to Dec 25, 1921, that I last saw h[illegible] alive on Dec 25, 1921, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Cystitis Chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Dec 28, 1921 (Address) 1279 Hillsdale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	12-29 1921

20 UNDERTAKER: E & B Stahle — ADDRESS: 115 E West St

CAUSE OF DEATH to be filled in plainly, using no abbreviations. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59687

79-091 D 59687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Cohn
Old aged Home Hebrew Hospital

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Aaron Cohn

6 DATE OF BIRTH (month, day, and year) Unknown 1820

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	101			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records
(Address)

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/22/21, 19 ... to 12/25/21, 19 ..., that I last saw her alive on 12/25/21, 19 ..., and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ... Zozinberg ... M. D.

12/25, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Orphan's	Dec 27 1921
20 UNDERTAKER	ADDRESS
Harry Goodman	1000 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Lochner

Spec. 6-9-19 H. R. Co. 1000 Bks.

D 59688

HEALTH DEPARTMENT—CITY OF BALTIMORE

59688

CERTIFICATE OF DEATH.

691

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 N. Rose ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Lochner

(a) RESIDENCE. NO. 430 N Rose ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General natore of indostry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Joseph Lochner

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Anna Zerda

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Anna Lochner

(Address) 430 N Rose St

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1921 to Dec 24 1921

that I last saw him alive on Dec 25 1921

and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

PDW

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

1921 (Address) 600 N Bell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 27 1921
20 UNDERTAKER	ADDRESS
Paul Enoch & Son	1116 Caroline

CAUSE OF DEATH must be plainly written. Statistical particulars are required by law. Every question must be answered. Write plainly with pen and ink. Use no abbreviations. Do not use ditto marks. Be particular and write correctly. Do not omit any information which you may possess. A CAUSE OF DEATH must be given. If unknown, state the fact. Indefinite statements are insufficient. If the disease is not of long duration, give also the CAUSE OF DEATH of the last illness. Thus, Pneumonia, Influenza, Bronchitis, Exhaustion, Heart Failure, etc., are not sufficient. Deaths from violence must state the MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Where there has been a recent injury, the fact and date should be stated. Where a woman has died during pregnancy, childbirth, or abortion, the fact should be stated. The PLACE OF BURIAL, CREMATION OR REMOVAL, the DATE OF BURIAL, and the NAME AND ADDRESS OF UNDERTAKER must be given. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior
to pneumonia

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59689 — 79 D 59689

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 N Fayette ST.; 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Booze

(Residence in Baltimore: No. 927 N Fayette St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1876 (Year)

7-AGE, 45 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Boss Tinner
(b) General nature of industry, business, or establishment in which employed (or employer)..... 044

9-BIRTHPLACE, (State or Country), Balto Co Md.

PARENTS.

10-NAME OF FATHER Wm Booze

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maggie Moore

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Booze

(Address) 927 N. Fayette St.

15- DEC 27 1921 Filed....., 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 24 1921, that I saw h[illegible] alive on Dec 20 1921, and that death occurred, on the date stated above, at 7 20 P.M.

The CAUSE OF DEATH* was as follows: Pneu

Pneumonia Lobar

Contributory Exhaustion

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration)..... yrs. ..... mos. 1 ds.

(Signed) J. K. Hamburger M. D.

Dec 20, 1921 (Address) 1120 Mills

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel

DATE OF BURIAL, Dec 28, 1921

20-UNDERTAKER Daniel Eareckson

ADDRESS, Dec 28 916 Mass Ave

Cut on dotted line and paste on board of certificate. See instructions on back of certificate.

Endocarditis Compensatory hypertrophy. Not etc.
Not Quite. No further history

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59690

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

47 D 59690

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Scott

(a) RESIDENCE. No. 1108 Shields St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of wnrk Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Priscilla Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carrol Co., Maryland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 FILED DEC 27 1921 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1921

17

I HEREBY CERTIFY, That I attended deceased from December 12. 1921, to December 24. 1921, that I last saw her alive on. December 23. 1921, and that death occurred, on the date stated above, at 3 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds. Rheumatic endocarditis (duration) 10 (?) mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

12/24/ 21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 28 1921
20 UNDERTAKER	ADDRESS
David Taylor	916 Gay

CAUSE OF DEATH in plain terms, so that it may be understood by all. Name of disease alone is not sufficient. Omission of any item of information called for by this certificate will delay burial. Every question must be answered. Write plainly with pen and ink. Use no abbreviations. Do not use ditto marks. Be sure to make a perfect and complete return. Every certificate must be signed. Do not fail to sign your name. Read carefully the instructions on back of certificates. ATTENTION is very important. See instructions on back of

Robert Campbell 1644 Hanover St ✓

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59691 — 29 D 59691

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Fawson ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna J. Miller

(a) RESIDENCE NO. 1412 Fawson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Miller

6 DATE OF BIRTH (month, day, and year) Sept 9. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Peter A. Gottsleben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant William Miller (Address) 1412 Fawson St

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 21, to Dec 26, 19 21, that I last saw h alive on Dec 26, 19 21, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Ephanciton

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. H. Campbell M. D.

Dec 27, 1921 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 28 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59692

CERTIFICATE OF DEATH.

176D 59692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. St. 4th Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Single

(a) RESIDENCE. No. 725 So. Montford Ave. Ward. 1st

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~ ~~Married~~ Widowed, or Divorced (write the word)
M	W	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elyabeth Single

6 DATE OF BIRTH (month, day, and year) 1846, Feb 8

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75		10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster packer 176

(b) General nature of industry, business, or establishment in which employed (or employer) J. S. Tarren Packing Co

(c) Name of employer J. S. Tarren

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Michael Single.

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Beach

15 Filed DEC 27 1921, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1921, to Dec 25, 1921, that I last saw h... alive on Dec 25, 1921, and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy.
Cystitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, hypertension, heart failure. (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 725 So. Montford Ave.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination

(Signed) Julian D. Hart, M. D.

, 19 (Address) Johns Hopkins Hosp. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Dec 29 1921
20 UNDERTAKER	ADDRESS
A. Sander & Sons	718 Flat St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59693

CERTIFICATE OF DEATH.

64 D 59693

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 515 N. Mount St ST.: 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Cuff

(Residence in Baltimore: No. 515 N. Mount St ST.: 52 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) wdw

6-DATE OF BIRTH, ... Unknown (Month) ..., 1843 (Day) (Year)

7-AGE, ... 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ward Benn

11-BIRTHPLACE OF FATHER (State or Country) Md.

12-MAIDEN NAME OF MOTHER Douglass

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Benn

(Address) 515 N. Mount St

15- Filed DEC 27 1921 401 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 24, (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) ad Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Dec. 27 1921 (Address) 2807 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec 28 1921

20-UNDERTAKER Brown & Gutman ADDRESS 114 N Schroeder St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59694

D 59694

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2610 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Jablonski

(Residence in Baltimore: No. 2610 Hudson St.; ....yrs., 2 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, Oct 17, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael Jablonski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Mary Milenko

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jablonski

(Address) 2610 Hudson

15- Filed DEC 27 1921, 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

CAUSE OF DEATH must be plainly stated. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 25 1921, that I saw h[illegible] alive on Dec 25 1921, and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

His - colitis

(Duration) yrs. ca 4 wks mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

12/27.6...., 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	Dec 27, 1921
20-UNDERTAKER	ADDRESS
John H Weber	1803 Bank

D 59695

HEALTH DEPARTMENT—CITY OF BALTIMORE

169 59695

CERTIFICATE OF DEATH.

REGISTERED No. C

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 3 East of Boralma St. ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Peter Kyc.

(Residence in Baltimore: No. 724 S Bond St

St.; yrs. 56 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, March 15, 1865
(Month) (Day) (Year)

7-AGE. 56 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Oil

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kyc

(Address) 724 S Bond

15-

Filed DEC 27 1921 191 ROBERT R. KRAUTER,

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Theus Lyon Smith M. D.
(Coroner.)

Dec 27, 1921 (Address) 800 Fidelity Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Dec 28, 1921

20-UNDERTAKER John M Weber — ADDRESS 1803 Eank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59696

D 59696

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

City of Baltimore (No. 3338 Eastern Ave St. 1 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kazimierz Majchrzak

(Residence in Baltimore: No. 3338 Eastern Ave St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 31 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retail Grocer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Joseph Majchrzak

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Josefa Jezorawski

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Majchrzak

(Address) 3338 Eastern Ave

DEC 27 1921 ROBERT R. KRAUTER,

Filed ....., 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) Investigation find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

1 Yr (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Gan M.D.
Coroner.

Dec 27, 1921 (Address) 1800 Gholl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus.

DATE OF BURIAL, Dec 28, 1921.

20-UNDERTAKER M. F. Ladowski.

ADDRESS 705 S. Ann St.

N. B.—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Robert-G. Helgenberg ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

59697

CERTIFICATE OF DEATH.

104

D 59697

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Bishop Road ST.; Guilford WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert George Helgenberg

(a) RESIDENCE. NO. 12 Bishop Road ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 21-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (City or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Carl Helgenberg

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Angelica Rogge

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Carl Helgenberg
(Address) 12 Bishop Rd

15 DEC 27 1921 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1921, to Dec 26, 1921, that I last saw him alive on Dec 25, 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Ileocolitis

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsion ✓

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Aubrich, M. D.

Dec 26, 1921 (Address) 11 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	12-28 1921

20 UNDERTAKER	ADDRESS
Leroy W. Jenkins Sons Co	Orchard & McCulloh

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59698 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 W Balto. St. 19th WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Fulkoske

(a) RESIDENCE. No. 1311 W. Balto ST., 19th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W. Late	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aug Fulkoske

6 DATE OF BIRTH (month, day, and year) April-4-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	Yrs	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Aug. Kuschke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Geo. L. Fowler

(Address) 1311 W. Balto. St

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24/21

17 I HEREBY CERTIFY, That I attended deceased from April 2 1921, to Dec. 24, 1921, that I last saw her alive on Dec. 24, 1921, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri (Cervix)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) E Hellen Hemming, M. D.

12/27 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 27 1921

20 UNDERTAKER: F B Wenpert — ADDRESS: 2236 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59699 — 20 — D 59699

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General St.: Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Pauley

(a) RESIDENCE. NO. 404 N. Curley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ J. J. Pauley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belle Vue

PARENTS

10 NAME OF FATHER Elizabeth Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Unknown?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lillie Pauley

(Address) 404 N. Curley St.

15 Date DEC 27 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23- 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/21 , 1921, to 12/23 , 1921, that I last saw h er alive on 12/23 , 1921, and that death occurred, on the date stated above, at 10-½ m.

The CAUSE OF DEATH* was as follows:

Cellulitis & Phlegmon Perineal & Scrotal

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 404 N Curley St

Did an operation precede death? yes Date of 12/22/21

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W D Douglas, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	12-27 1921
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Origin of cellulitis and septicaemia unknown.

D 59700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59700

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2821 N. Monk Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A. Burgess

(Residence in Baltimore: No. 2821 N. Monk ave. St.; 1 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, July 14, 1833 (Month) (Day) (Year)

7-AGE, 88 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....at home....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Bates

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie Denny

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Jennings

(Address) 2821 N. Monk ave

15- Filed DEC 27 1921, 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquest.... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ....inquest.... (Inquest, autopsy or inquiry) find that said deceased came to ....death.... on the day stated above.

The CAUSE OF DEATH* was as follows:

....Organic heart disease....

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Dec. 27, 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Burgess Store Va | DATE OF BURIAL, Dec. 27 1921

20-UNDERTAKER Harry W. Ehlen | ADDRESS 1948 W. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence to street number important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Jeffers. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59701

CERTIFICATE OF DEATH.

79 D 59701

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2269 W. Baltimore St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna E. Jeffers.

(Residence in Baltimore: No. 2269 W. Baltimore St.; 12 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept. 21, 1909.
(Month) (Day) (Year)

7-AGE, 12 yrs. 3 mos. 3 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, Frank M Jeffers

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Alice [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank M. Jeffers

(Address) 2269 W. Balto St.

15- Filed DEC 27 1921, 191.... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 25, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22. 1921, to Dec 25. 1921, that I saw h[illegible] alive on Dec 25. 1921, and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(Duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 5 da.

(Signed) J. H. Wilson M. D.

1925. 21, 191. (Address) 1735 Eutaw

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Dec 28 1921.

20-UNDERTAKER H. M. Rowson — ADDRESS 2238 N. Mott

CAUSE OF DEATH in plain terms. Be sure to answer every question. All items important. See instructions on back of certificate.

D 59702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1755 103

59702

REGISTERED No. C

1-PLACE OF DEATH Pronounced Dead at Maryland University Hospital

CITY OF BALTIMORE (No. ~~Highlands~~ Station W. B & A R.R. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Waldorf L. Worden -

(Residence in Baltimore: No. Camp Meade Md. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE, 26 yrs. mns. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Soldier U.S.A.
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.S.A.

9-BIRTHPLACE, (State or Country), Conn.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. M. Routson

(Address) 230 N. Greene St.

15-

Filed DEC 27 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, au~~ ~~topsy or~~ inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & internal Injuries

(Duration) a few miles da.

CONTRIBUTORY (Secondary) Struck by W. B & A R.R. train

(Duration) yrs. a few miles mos. ds.

(Signed) W. K. Grossmann M. D.
(Coroner)

12-27-, 1924. (Address) 11 J. W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mns.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Camp Meade Md

DATE OF BURIAL, Dec 27 1924

20-UNDERTAKER H. M. Routson

ADDRESS 230 N. Greene

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59703

CERTIFICATE OF DEATH.

1579 D 59703

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 45 Cedar St. Curtis Bay. ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Hube.

(Residence in Baltimore: No. 45 Cedar St. Curtis Bay. St.: 25 yrs.. ---------- mos. ---------- ds.)

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, December 24th, 1842. (Month) (Day) (Year)

7-AGE, 78 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): Of

9-BIRTHPLACE. (State or Country). Lithuania.

PARENTS.

10-NAME OF FATHER. Gottlied Hube.

11-BIRTHPLACE OF FATHER (State or Country). Lithuania.

12-MAIDEN NAME OF MOTHER Charlotta -----.

13-BIRTHPLACE OF MOTHER (State or Country). Lithuania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Topfele Grube. (daughter).

(Address) 45 Cedar St. Curtis Bay.

15- Filed DEC 8 1921 1921 ROBERT R. KRAMER Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 23rd. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reynolds M. D. (Coroner.)

Dec. 23rd, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL, OR REMOVAL, St. Mathias Cem. DATE OF BURIAL, Dec. 27 1921

20-UNDERTAKER Margaret G. Flynn ADDRESS 432 High St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59704

CERTIFICATE OF DEATH.

97D 59704

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Maryland ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Goodwin

(Residence in Baltimore: No. 1805 Maryland ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Mar'd

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, ..1.. yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bull City

PARENTS.

10-NAME OF FATHER, Charles Goodwin

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Goodwin

(Address) 1805 Maryland

15- Filed DEC 27 1921, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..Inquest.. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..Inquest.. (Inquest, autopsy or inquiry.) find that said deceased came to ..his.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

..(1)..Lobar Pneumonia.....

.....

.....

..2..days (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) ..W. Wesley.. (Coroner.) M. D.

Dec 25, 1921 (Address) 1659 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL DEC 28 1921

Commissioner of Health

per Wm. E. WOODALL,

18780

N. B.—Every item of information should be carefully given, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59705

CERTIFICATE OF DEATH.

28 D 59705

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Jones

(a) RESIDENCE. No. 129 Jones Court (?) ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer U40

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Frank Marabel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Marabel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed DEC 27 1921 19 ..... Registrar

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15th, 19 21, to Dec. 23, 19 21, that I last saw him alive on Dec. 23, 19 21, and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Padaglinda, M. D.

12-23-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 27 1921 19
20 UNDERTAKER	ADDRESS

ROBERT R. KRAUTER, Assistant Clerk

Commissioner Health.

Asst. Clerk S. WOODALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 59706

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Lyles

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75 ? about			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed DEC 27 1921 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from December 21 1921, to December 22 1921, that I last saw her alive on December 22, 1921, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to Liver

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

12/24/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL DEC 28 1921
20 UNDERTAKER	ADDRESS

Commissioner Health,

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H P Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15-24-25 D 59707 151 D 59707

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A Revis

(a) RESIDENCE. NO. Curtis Bay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ernest Revis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Cartwright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL Henrietta

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-19, 1921, to 12-25, 1921, that I last saw him alive on 12-25, 1921, and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus

OVER

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. A. Marsh, M. D.

, 19 (Address) Harriet Lane Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	DEC 2 1921
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Premature birth

Spec.—8-24-14—M. & T.—2000 Blks.

D 59708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 59708

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 N. Dorchester ST.; 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Pullmann

(Residence in Baltimore: No. 115 N Dorchester Ave St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, April (Month) 1st (Day), 1841 (Year)

7-AGE, 80 yrs. 8 mos. 22 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor 60
(b) General nature of industry, business, or establishment in which employed (or employer): at Hamberger

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Geo F Pullmann

(Address) 115 N Dorchester Ave

15-

Filed ....., 191.... ROBERT R. KRAUTER Registrar.

DEC 27 1921 Burial Permit Clerk.

CAUSE OF DEATH to be plainly written, and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 23rd (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1921, to Dec 23rd 1921, that I saw h.. alive on Dec 23 1921, and that death occurred, on the date stated above, at 5. A m.

The CAUSE OF DEATH* was as follows:

Acute Dilat. Cardiac

Failure

Duration 3 wk yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) ..... M. D.

Dec 24, 1921 (Address) ..... Interne

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem

DATE OF BURIAL, Dec. 27, 1921.

20-UNDERTAKER Peter Nicolaus

ADDRESS 1646 Eastern

Chronic Nephritis. Acute attack

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59709

CERTIFICATE OF DEATH.

170 D 59709

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4900 Denmore ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Fuller Shryock

(a) RESIDENCE. No. 4900 Denmore Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE)~~ Maggie B Shryock

6 DATE OF BIRTH (month, day, and year) May 30 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry D Shryock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ann Shields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Maggie B. Shryock
(Address) 4900 Denmore ave

15 Filed [illegible] 19 ROBERT R. PRASTER Burial Permit Clerk Registrar

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1921

17
I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to Dec 26, 1921, that I last saw him alive on Dec 25, 1921, and that death occurred, on the date stated above, at 9.10 A m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis, Pulmonary Congestion and Intermittent Heart Block
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis & Auscultation

(Signed) C. D. Emmor, M. D.

19 (Address) 506 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Dec 28 1921

20 UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59710

CERTIFICATE OF DEATH.

19 D 59710

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 702 E. 33rd St. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Hicks

(a) RESIDENCE. No. 702 E. 33rd St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Hicks

6 DATE OF BIRTH (month, day, and year) July 19-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Canner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER John Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Amanda E. Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermuda

14 Informant (Address) Mrs. Rose Hicks 702 E. 33rd St.

15 Filed DEC 27 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1921, to Dec 25, 1921, that I last saw him alive on Dec 25, 1921, and that death occurred, on the date stated above, at 9 P.M. The CAUSE OF DEATH* was as follows:

Cerebral Asthenia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. (1) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Wm. L. Brenneman, M. D.

19[illegible] (Address) 918 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Dec. 28 1921

20 UNDERTAKER	ADDRESS
Wm. L. Black	927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3003 Clifton ave. ST.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Rickard

(a) RESIDENCE. No 3003 Clifton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, ~~divorced~~ HUSBAND of (or) WIFE of Sarah Rickard

6 DATE OF BIRTH (month, day, and year) May 4 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER Wm Rickard

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Jane Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Virginia

14 Informant Mrs. Lena Gresham

(Address) 3003 Clifton ave

15 Filed DEC 27 1921 19

ROBERT P. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1921, to Dec. 25, 1921, that I last saw him alive on Dec. 24, 1921, and that death occurred, on the date stated above, at 7.00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy. (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. K. C. Adkins M. D.

(Address) 2705 W. Monta

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Falling Waters W. V.	Dec. 28 1921
20 UNDERTAKER	ADDRESS
Wm E. Black	927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information of [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59712 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

64 D 59712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Little Sisters of the Poor ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Ross

(a) RESIDENCE. NO. Preston & Valley St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dan Ross.

6 DATE OF BIRTH (month, day, and year) Dec 21-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Parnell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Lydia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sister Florence

(Address) Preston Ward.

15 Filed DEC 27 1921, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 , to , 19 , that I last saw h[illegible] alive on Dec 18, 1921, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows: Over

Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Dec 26, 1921 (Signed) F. A. Warner, M. D (Address) 1137 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Dec 28- 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF DISEASE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Apoplectic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59713

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 S. Kenwood Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Doyle Sr.

(a) RESIDENCE. NO. 1021 S. Kenwood Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Doyle.

6 DATE OF BIRTH (month, day, and year) March 5-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Thomas Doyle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Margaret Doyle.

(Address) 1021 S. Kenwood Ave.

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk.

C 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Dec 25, 1921, that I last saw h— alive on Dec 24, 1921, and that death occurred, on the date stated above, at 5.00 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M J McAvoy, M. D.

12/26, 1921 (Address) 839 S. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec. 28 1921
20 UNDERTAKER Lilly & Zirkin	ADDRESS 403 S. Wolfe St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 59714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Sydenham Hospital ST. (OR WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justin R. Kinsey

(a) RESIDENCE No. 718 E. 22nd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 2-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ontario Canada

PARENTS

10 NAME OF FATHER Justin R. Kinsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mich

12 MAIDEN NAME OF MOTHER Augusta P. Gilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Justin R Kinsey
(Address) 718 E 22nd St

15 Filed ..... 19 ..... Registrar

27 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1921, to Dec 27, 1921, that I last saw him alive on Dec 27, 1921, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? culture (+)

(Signed) B. MacNevin M. D.

(Address) Sydenham Hospital. 12/27/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 27 1921

20 UNDERTAKER	ADDRESS
William Cook	502 E Nat Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

(Anderson)

D 59715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159 D 59715

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1231 n Patterson Pk (St.) 8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frank C Anderson.

(Residence in Baltimore: No. 1231 n Patterson Pk St.; yrs., 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, February 5, 1895
(Month) (Day) (Year)

7-AGE, 26 yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Public School

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Charles Anderson

11-BIRTHPLACE OF FATHER (State or Country), Sweden

12-MAIDEN NAME OF MOTHER, Blenda Ulrickson

13-BIRTHPLACE OF MOTHER (State or Country), Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Anderson

(Address) 1731 N. Patterson Park Ave

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

DEC 27 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 25 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Poison

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) F Knox Ingley M. D.
(Coroner.)

12-27, 1921. (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, DEC. 29, 1921

20-UNDERTAKER H E Hughes

ADDRESS 1411 E. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59716

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—(No. 14 E. Fort Ave ST. 73 WARD)

2-FULL NAME Minnie Grebe

(a) RESIDENCE. NO. 14 E. Fort Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Grebe

6 DATE OF BIRTH (month, day, and year) May 17 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John C. Sommerhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Bonner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Grebe
(Address) 14 E Fort Av.

15 Filed Robert P. Harrison Registrar

C 27 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1921, to Dec 26, 1921, that I last saw her alive on Dec 26, 1921, and that death occurred, on the date stated above, at 11 45 A.M.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

Disease (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hagerman M. D.

12/27/1921 (Address) 1 E Randall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 29 1921

20 UNDERTAKER B Lehmann & Sons

ADDRESS Lauvier

CAUSE OF DEATH in plain terms, so that it may be properly classified. Full statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59717 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59717

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Calhoun ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Watts,

(a) RESIDENCE No. 1020 Calhoun St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Watts,

6 DATE OF BIRTH (month, day, and year) 7/5/1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Rubbish

(c) Name of employer Contractor

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George W. Towers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Edna Barrett 1424 Division Ave

15 Filed 27 1921 16 Robert P. Harrison, Registrar

Record Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/26/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1921, to 12/26/ 1921, that I last saw him alive on Dec. 24th 1921, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Lee Ellis, M. D.

, 19 (Address) 92 Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 28th 21
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59718

CERTIFICATE OF DEATH.

79 D 59718

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 N. Caroline ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Boone

(a) RESIDENCE NO. 1839 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) Oct 10 - 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71.	2.	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Saml. R. Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Adair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Saml. R Boone

(Address) 2207 Homewood Av

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1924, to Dec 26, 1924, that I last saw her alive on Dec 25, 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Dillon Young M. D.

Dec 27 1924 (Address) 1107 Springfield Bld'g

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount View Cemetery Baltimore Co	Dec 28 1921
20 UNDERTAKER	ADDRESS
Wm Cook & Son	502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59719

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Alice Virginia Nichols ST.: 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 1500 W. Lanvale St.

(Residence in Baltimore: No. 1500 W. Lanvale St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	married

6-DATE OF BIRTH, Dec. 6, 1854
(Month) (Day) (Year)

7-AGE, 67 yrs. mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). a. a. Co, Md.

PARENTS.

10-NAME OF FATHER. Thos. H. Arnold

11-BIRTHPLACE OF FATHER (State or Country). a. a. Co, Md

12-MAIDEN NAME OF MOTHER Rebecca Warren

13-BIRTHPLACE OF MOTHER (State or Country). a. a. Co, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. W. B. Nichols
(Address) 1500 W. Lanvale St.

15-
Robert P. Harrison,
Filed....., 191.....
Burial Permit Clerk. Registrar.

27 1921

N. B. Every item of information must be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull
20 minutes
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Automobile accident
(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)
Dec 27, 1921 (Address) 202 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 28 21

20-UNDERTAKER Bertram Fox — ADDRESS 1723 N. Howard St

Spec.—6-9-19—H. P. Co.—1000 Blks.

De Witt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59720

D 15-7-91 D 59720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Talbot De Witt

(a) RESIDENCE. NO. 1114 Fort Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-26-21.

7 AGE: Years | Months 1 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leonard De Witt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed DEC 28 1921 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1921, to 12-26, 1921, that I last saw him alive on 12-26, 1921, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis.

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? none.

(Signed) Chas Bond Mason, M. D.

Dec 27 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Dec. 28 1921
20 UNDERTAKER	ADDRESS 2016 Orleans St
Philip Herwig	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 v

D 59721

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Overland av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Geo. and Emma Turner

(Residence in Baltimore: No. 712 Overland av St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 26, 1921.
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....1.....da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... gen'l

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Geo Grover Turner

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Emma Knolle

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Geo. Turner

(Address)..712 Overland

15-

Filed DEC 28 1921 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit ISSUED

CAUSE OF DEATH in plain terms, as may be most important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 1921, to Dec 27 1921, that I saw h[illegible] alive on Dec 26 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis of right lung

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Congenital atelectasis of right lung

(Duration)....yrs....mos....ds.

(Signed)..Chas. Sumwalt.....M. D.

Dec 27 1921 (Address) 1706 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Stevensons Run

DATE OF BURIAL, Dec 28th, 1921.

20-UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59722

CERTIFICATE OF DEATH.

5 D 59722

1-PLACE OF DEATH Gaunt Hosp

CITY OF BALTIMORE: (No. ~~3025 Cal~~ ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Summers

(a) RESIDENCE. No. 3625 Calhoun ST., 19 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 27 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Norman Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elsie F Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Norman Summers
(Address) 302 N Calhoun

15 Filed DEC 28 1921 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1924, to Dec 27, 1924, that I last saw h[illegible] alive on Dec 27, 1924, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia both
(6½ mos)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

12/27 1924 (Address) 1302 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 28 19
20 UNDERTAKER	ADDRESS
John J Fields	120 N Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

59723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59723

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2126 Mc Elderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stewart

(a) RESIDENCE. NO. 2126 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Colored	Female	Sing

5a If married, widuwed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54 years	—	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Freddie Stewart
(Address) 2126 Mc Elderry St

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1921, to Dec. 24, 1921, that I last saw h[illegible] alive on Dec. 23, 1921, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) High Blood pressure (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson M. D.

12/27/21 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Jion. Cemetery Dec 28 1921

20 UNDERTAKER — ADDRESS

Milton Davis 315 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASED'S OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Caroline Skinner

D 59724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 59724

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N. Fulton Ave. St.; 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. John Skinner

(Residence in Baltimore: No. 627 N. Fulton Ave St.: 73 yrs., 9 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 4, 1848 (Month) (Day) (Year)

7-AGE, 73 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 637

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Rausch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret ?

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis L. Krauter

(Address) 627 N. Fulton Ave

DEC 28 1921

Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

Returned

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1921. to Dec 26 1921, that I saw h[illegible] alive on Dec 26 1921, and that death occurred, on the date stated above, at 2 p. m. The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Thomas E. Dowell M. D.

12/26, 1921. (Address) 735 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, Dec. 28, 1921.

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59725

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D 59725

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 542 E Fort Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence M. Montgomery.

(a) RESIDENCE. No. 542 E Fort Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Montgomery

6 DATE OF BIRTH (month, day, and year) Feb. 13 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter at Dry Docks

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Montgomery (Address) 542 E. Fort Ave.

15 DEC 28 1921 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22. 1921. to Dec 27. 1921. that I last saw him alive on Dec 27. 1921. and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney H. Street M. D.

12/27 1924 (Address) 408 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	12/29 1921
20 UNDERTAKER	ADDRESS
J. Fenw M. Cully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59726

HEALTH DEPARTMENT—CITY OF BALTIMORE

29

D 59726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1417 Olive ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Gottschalk

(a) RESIDENCE. No. 1417 Olive ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Gottschalk

6 DATE OF BIRTH (month, day, and year) — 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hannemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto Gottschalk

(Address) 1417 Olive St

15 Filed DEC 28 1921 ROBERT R. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1921 to Dec 26 1921, that I last saw her alive on Dec 26 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Phthisis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. Hamman Lynch M. D.

Dec 27, 1921 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 29 1921
20 UNDERTAKER	**ADDRESS**
Geo Leimbach & Son	647 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 59727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 59727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N. Monroe St. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olof Johnson

(a) RESIDENCE NO. 305 N. Monroe St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalena Johnson

6 DATE OF BIRTH (month, day, and year) July 29" 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Mrs. Magdalena Johnson

(Address) 305 N. Monroe St.

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27" 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 11 1921 to Dec 27 1921, that I last saw h-his alive on Dec 27 1921, and that death occurred, on the date stated above, at 12.40A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(duration) yrs. 2 mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory.

(Signed) H N King, M. D.

, 19 (Address) 651 N. Franklin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Dec 29 1921

20 UNDERTAKER: Joseph B Cook — ADDRESS: 1003 N. Eutaw St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Roberts

D 59728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59728

CERTIFICATE OF DEATH.

87

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2919 Riggs Ave. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Clayton Roberts

(a) RESIDENCE NO. 2919 Riggs Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 14" 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Clarence A. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Beulah E. Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clarence A. Roberts (Address) 2919 Riggs Ave.

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26" 19 21

17

I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921, to Dec 26, 1921, that I last saw him alive on Dec 26, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Oedema of Larynx + Trachea

(duration) yrs. 15 hours mos. ds.

CONTRIBUTORY (Secondary) Possibly diphtheria?

(duration) yrs. 15 hours mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Suggestion by Health dept. agent

(Signed) Chas. H. Conner M. D.

(Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem.

DATE OF BURIAL Dec 28, 1921

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 E Balto St

Information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Avoid use of abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OFFICE HOURS:
8 TO 10 A. M.
3 TO 4 P. M.
AND BY APPOINTMENT
TELEPHONE.

DR. CHARLES O'DONOVAN,
No. 5 EAST READ STREET.

59728

BALTIMORE, Jany 2 1922.

Dear Dr. Hogan.

In reference to the case of John Roberts, 219 Biggs Ave who died Dec 25th last, & whose certificate of death read "Oedema of the glottis, possibly diphtheria", I wish to eliminate the words "possibly diphtheria", since no evidences of diphtheria were found at the time of his illness by me or by Dr. Cooper, in consultation, nor did any of the cultures taken from the various members of the family show positive for that disease, nor has any further diphtheria developed in the house or family.

Very truly Yours

Chas. O'Donovan

Spec.—6-9-19—H. P. Co.—1000 Bks.

Marcia Gray

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59729

CERTIFICATE OF DEATH.

108 D 59729

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland Gen. Hosbt ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME marcia Grey

(a) RESIDENCE. NO. 540 N. Milton ave, ST., WARD. Baltimore, md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	5	4	

8 OCCUPATION OF DECEASED Child

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elliott, md.

PARENTS

10 NAME OF FATHER John W. Grey Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elliott, md.

12 MAIDEN NAME OF MOTHER Pearl Jarrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elliott, md.

14 Informant Mother above address.
(Address)

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Dec 26, 1921, that I last saw h e alive on Dec 26, 1921, and that death occurred, on the date stated above, at 4:57 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis

Acute appendicitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? no - Date of Dec 24, 1921

Was there an autopsy?

What test confirmed diagnosis? Surgeon.

(Signed) Wm. D. Douglass. M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 29 1921
20 UNDERTAKER Mrs. C. Fuller	ADDRESS 2334 Jefferson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59730

CERTIFICATE OF DEATH.

170 D 59730

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2416 Buchanan ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Johnson

(a) RESIDENCE. NO. 2416 Buchanan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of Industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in St-Marys Co Md lived in Balt-30 years

PARENTS

10 NAME OF FATHER Isaac Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ashman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Sadie Washington

(Address) 749-Eastern Ave

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 2 1921 to Dec 24 1921, that I last saw h alive on Dec 24 1921, and that death occurred on the date stated above, at 5-45 m.

The CAUSE OF DEATH was as follows:

Brights Disease.

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) R. Garland Chandlee, M. D.

Dec 27 1921 (Address) 1334-E.N.Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 27 1921
20 UNDERTAKER	ADDRESS 725-Ashland Av
Mrs Robert F Elliott	

mation should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59731

HEALTH DEPARTMENT—CITY OF BALTIMORE

156 D 59731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE No. 864 W Fayette St. 18 WARD)
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P. Meyers
(Residence in Baltimore: No. 864 W Fayette St
St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married
6-DATE OF BIRTH, May 4, 1876
(Month) (Day) (Year)
7-AGE, 45 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), Maryland

PARENTS.
10-NAME OF FATHER, John P Meyers
11-BIRTHPLACE OF FATHER (State or Country), Austria
12-MAIDEN NAME OF MOTHER, Pauline Klier
13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John P Myers
(Address) 3411 Hudson St

15- DEC 28 1921 ROBERT R. KRAUTER,
Filed ....., 191.... Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy~~ or inquiry) thereon and from the evidence obtained by said ..... (~~Inquest, au~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Inhalation Pneumatory Gas
(Duration) yrs. 45 mos. ds.
CONTRIBUTORY (Secondary) Suicide
(Duration) yrs. mos. ds.
(Signed) H B Gaugler M. D.
(Coroner)
12.28. 1921 (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park
DATE OF BURIAL, Dec 28 1921
20-UNDERTAKER Ellyson Zahn
ADDRESS 813 N Howard St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59732

CERTIFICATE OF DEATH.

104 D 59732
REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 W. Lexington ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Giuseppe Liberto

(Residence in Baltimore: No. 511 W. Lexington St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Sing'g

6-DATE OF BIRTH, Dec (Month) 14 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. 15 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Charles Liberto

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Spinato

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicolas Spinato

(Address) 511 W Lexington W

15- Filed DEC 28 1921 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1921, to Dec 28 1921, that I saw h-m alive on Dec 27 1921, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Luigi DiStefano M. D.

Dec 28, 1921 (Address) 407 W. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 28th, 1921.

20-UNDERTAKER Lilly & Fiedler — ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59733

CERTIFICATE OF DEATH.

64

D 59733

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 Park-Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maude Mary Elizabeth Mitchell.

(a) RESIDENCE. No. 1918-Park-Ave. ST., 13 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? 55 yrs. 4 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	(Single)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: (Single)

6 DATE OF BIRTH (month, day, and year): Aug-20-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer): Teaching

(c) Name of employer: (self)

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Henry Mozart Mitchell.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland.

12 MAIDEN NAME OF MOTHER: Elizabeth A. McComas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): White Hall, Baltimore Co. Maryland

14 Informant: Miss Lillian M. Mitchell (sister)
(Address) 1918-Park-Av. City.

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar
Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 27 — 1921.

17 I HEREBY CERTIFY, That I attended deceased from 3:30 p.m. Dec. 27, 1921, to 5:00 p.m. Dec. 27, 1921, that I last saw h[illegible] alive on Dec 27th, 1921, and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)
of about 5 hours.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary): Sclerosis high B.P.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? None necessary

(Signed) Eleanor C. Price, M. D.

Dec. 29, 1921 (Address) 1002 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GREENMOUNT CEMETERY	Dec-31-1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM P. WOODEN, Successor) ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. Attention is called to the fact that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59734

CERTIFICATE OF DEATH.

91 D 59734

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 W. Cross ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Frank Girlando

(a) RESIDENCE. NO. 114 W. Cross St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 1½ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26-1919

7 AGE 2 Years 11 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Biagio Girlando

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Noemi Stuzi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Biagio Girlando (Address) 114 W. Cross St.

15 Filed DEC 28 1921, 19.... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27-1921

17 I HEREBY CERTIFY, That I attended deceased from 12-27-, 1921, to 12-27-, 1921, that I last saw h[illegible] alive on 12-27-, 1921, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis.

(Signed) J. Dinaro M. D.

, 19 (Address) 1637 Lindenau.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 29 1921
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of any infection prior.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59735

64 D 59735

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hut Long Reservoir House ST., 13 WARD)

2-FULL NAME Laura Musser

(a) RESIDENCE NO. Hut Royal Reservoir House ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Musser

6 DATE OF BIRTH (month, day, and year) 8 20 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Laura Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emmitsburg Md

14 Informant William Bushman

(Address) 502 W. 32 St.

15 Filed DEC 28 1921 Registrar ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Dec 27, 1921.

that I last saw her alive on Dec 26, 1921.

and that death occurred, on the date stated above, at 12.20 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Donoghue, M. D.

Dec 27 1921 (Address) 2436 Maryland Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Dec. 29 1921

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford ave.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 81 D 59736

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 N. Rose ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fritz Fischer

(a) RESIDENCE NO. 25 N. Rose ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Fischer

6 DATE OF BIRTH (month, day, and year) July 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Minnie Penner (Address) 25 N. Rose St.

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921, to Dec 26, 1921; that I last saw h[illegible] alive on Dec 26, 1921 and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N. Meyer Jr., M. D.

12/27, 1921 (Address) 1638 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 12-28 1921

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Baltimore St.

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Came from Jersey. Here 8 mos.
No hemorrhage.

D 59737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59737

CERTIFICATE OF DEATH.

X 153

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 ST.: Ashland Ave WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Wilson

(Residence in Baltimore: No. 1017 Ashland av St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col.	Bby.

6-DATE OF BIRTH, nov 13, 21
(Month) (Day) (Year)

7-AGE, ...yrs. .....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

9-BIRTHPLACE, (State or Country), New York City

PARENTS.

10-NAME OF FATHER George Wood

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Wilson

(Address) 803 Lemdon Ave

15- DEC 28 1921 191 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lack of care,

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Smalley M. D.
(Coroner)

12-27 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence New York City

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemtry	12/28/21

20-UNDERTAKER Filz B. Pyz ADDRESS 1022 Mulberry St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59738

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1043 N. Mount ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell E. Berry

(a) RESIDENCE. NO. 1043 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug. 31. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Anderson Wilson Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mt. Jackson Virginia

12 MAIDEN NAME OF MOTHER Maria Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bolts, Md.

14 Informant Father: Anderson W. Berry (Address) 1043 N. Mount St.

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-26 1921, to 12-27 1921, that I last saw him alive on 12-27 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 3 mos. 27 ds.

CONTRIBUTORY (Secondary) Hereditary Syphilis

(duration) yrs. 3 mos. 27 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Jas. Edw. Bull M. D.

. 19 (Address) 1224 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec 28 1921

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1239 Ethan St.

mation should be carefully supplied. AGE should be stated in YEARS. If it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59739

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59739

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7th WARD)

2-FULL NAME Baby girl Engelman

(a) RESIDENCE No. 3214 Forwood ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/18/21 11 P.M.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or mnts.
		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (no)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hebrew Hosp.

PARENTS

10 NAME OF FATHER Benjamin Engelman

11 BIRTHPLACE OF FATHER (city or town) Baltimore. (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Jacobson.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country) Germ.

14 Informant Hospital Records
(Address)

15 Filed DEC 28 1921 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28/1921

17

I HEREBY CERTIFY, That I attended deceased from 12/18/ .1921, to 12/28/ .1921,

that I last saw h Er alive on 12/28 .1921,

and that death occurred, on the date stated above, at 1:10 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.
Contusion OVER

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Post mortem Exam.

(Signed) Julius Wolfsohn, M. D.

.19 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave — DATE OF BURIAL: 12-28 1921

20 UNDERTAKER: Jack Lewis. — ADDRESS: 14 N. Eutaw

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. FIRST NAME should be written in full. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

After autopsy performed no peritonitis found. Dr. made diagnosis of peritonitis before autopsy. Clinical diagnosis. Primary cause of death was the pneumonia

Spec.—1-10-21 M&T 1500 Bks.

D 59740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 59740

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1228 E. Balto st ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Cordish

(a) RESIDENCE No 1228 E. Balto st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Cordish

6 DATE OF BIRTH (month, day, and year): — 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: -0

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Medvick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Emma Sherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1411 E Balto st

15 Filed DEC 28 1921 ROBERT R. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1921, to Dec 27, 1921, that I last saw h alive on Dec 27, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cerebral sclerosis

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Benj. Nadler M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Sec	12-28 1921

20 UNDERTAKER: Jack Lewis ADDRESS: 1411 E. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day, hours or minutes must CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59741 — 79 — D 59741

REGISTERED NO.....

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... St.: 12 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Carter

(a) RESIDENCE. No. 2457 Buchanan St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Carrie Carter

6 DATE OF BIRTH (month, day, and year) May 14 · 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Walter Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed DEC 29 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-16, 1921, to 12-26, 1921, that I last saw him alive on 12-26, 1921, and that death occurred, on the date stated above, at 10.35 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Emphysema

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam. + Electro-Cardiogram

(Signed) Francis R. Dimaide, M. D.

12/29, 1921 (Address) Johns Hopkins Hospital,

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Dec. 30 1921
20 UNDERTAKER	ADDRESS
Samuel Hemsley	570 N. Bell

JOHNS HOPKINS HOSPITAL
DEC 29 1921
ROBERT R. ...
Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. Particulars should be given as required, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 59742

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 N. Mulberry ST., 17 WARD)

2-FULL NAME Geraldine Gale

(a) RESIDENCE NO. 545 N. Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public School Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jerry Gale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Gough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Gough
(Address) 545 N. Mulberry St

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16th 1921, to Dec 26th, 1921.

that I last saw h[illegible] alive on Dec 26th, 1921,

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Enolly Miliary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of the Brain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) H. Lee Ellis, M. D.

12/27, 1921 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/29 1921
20 UNDERTAKER	ADDRESS
David T Hemsley	570 N Bond

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59743

D 59743

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 541 Bloom. St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Billingslea

(a) RESIDENCE. No. 541 Bloom. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. Billingslea

6 DATE OF BIRTH (month, day, and year) Uncertain 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jas. the Hill
(Address) 614 Lawrence

15 Filed . 19 Registrar

ROBERT R. KRAUTER, Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1921, to Dec 26, 1921, that I last saw her alive on Dec. 26, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cyphrenosis

(duration) yrs. mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos. Swagmp, M. D.

Dec 27, 1921 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Auburn Cem

DATE OF BURIAL Dec. 29 1921

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 59744

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1310 Ashland Ave ST., 10 WARD)

2-FULL NAME Victorine Gross

(a) RESIDENCE No. 1310 Ashland Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? [illegible] mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Francis X. Gross

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years: Abt 69 | Months: — | Days: — | If LESS than 1 day, ... hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: M. Silger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Miss Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: M. Edw G. Conway

(Address) 1223 E Chase St

15 Filed DEC 28 1921, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1921, to Dec 27 1921, that I last saw her alive on Dec 27 1921, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal and Pulmonary Tuberculosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. M. C. Parker, M. D.

Dec 27 1921 (Address) 1114 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincents Annex — DATE OF BURIAL: Dec. 29 1921

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 130 E Lanvale

N. B.—WRITE PLAINLY, with ordinary pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59745

REGISTERED NO. 154

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (a) No. 10 Magnolia Ave ST., Hamilton 27 WARD)

2-FULL NAME Sarah Wilson

(a) RESIDENCE No. 10 Magnolia Ave ST., Hamilton WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow.

5a If married, widowed or divorced HUSBAND of (or) WIFE of the late Stephen Wilson.

6 DATE OF BIRTH (month, day, and year) March 2nd 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmitsburg Md

PARENTS

10 NAME OF FATHER John Heard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Minter.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. William E. Wilson.

(Address) 10 Magnolia Ave

15 Filed DEC 28 1921, 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27, 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1921, to Dec 27, 1921.

that I last saw her alive on Dec 27, 1921

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David W. Cuthbertson M. D.

, 19 (Address) 5 W. Hamilton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 30 1921
20 UNDERTAKER Henry Hoerle Son	ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59746

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D 59746

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 N. Washington ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alford Lorony

(a) RESIDENCE. No. 131 N. Washington ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Lowry

6 DATE OF BIRTH (month, day, and year): Dec. 1850

7 AGE — Years: 71 — Months: — Days: 15 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Alford Lowry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Lillian Lorman
(Address) 1318 N. Washington St.

15 Filed DEC 28 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921, to Dec 27, 1921, that I last saw him alive on Dec 27, 1921, and that death occurred, on the date stated above, at 1230 p m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Cook, M. D.

12/27, 1921 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: Dec 29 1921

20 UNDERTAKER: Geo M. Smith & Son — ADDRESS: 811 N Wash St

A. B. C. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59747 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59747

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 726 S. Broadway ST. 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Demartin

(Residence in Baltimore: No. 721 S Broadway St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May 1, 1890
(Month) (Day) (Year)

7-AGE, 32 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Peter Demartin

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Julia Jorska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Julia Demartin

(Address) 714 S. Regester

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

DEC 28 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and thereon and from the evidence obtained by said Inquest, found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hark Dudley M. D.
(Coroner)

12-27, 1921 (Address) 416 Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross German Hill Road

DATE OF BURIAL, Dec 29, 1921

20-UNDERTAKER John McWeber

ADDRESS 1803 Bank St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 59748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green Sts. ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mckins.

(a) RESIDENCE. NO. 600 Sarah Ann. ST., WARD.
(Usual place of abode)
Length of residence in city or where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Will Mckins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Susan Johnson Johnson 12-26 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Aaron Mckins
(Address) 600 Block Sarah Ann St.

15 Filed ....., 19..... Registrar

DEC 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1921, to Dec 25th, 1921, that I last saw him alive on Dec. 25th, 1921, and that death occurred, on the date stated above, at 3 45/A. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. mos. 81 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL DEC 2 1921

18782

Commissioner Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Doris Beltz)

D 59749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59749

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 445 n Wolf St. 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Beltz

(Residence in Baltimore: No. 145 n Wolf St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	wht	Sing

6-DATE OF BIRTH. Dec 25, 1924. (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Walter Beltz

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Katherine Kerse

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Beltz

(Address) 145 N Wolf St

15- Robert P. Harrison,

Filed....., 191.... Burial Permit Clerk. Registrar.

6 28 1925

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 27, 1925. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. ds.

(Signed) Ernest Engler M. D.
(Coroner)

12-27-25, 191.. (Address) 7 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Matthews Cem

DATE OF BURIAL. Dec 29, 1925

20-UNDERTAKER J Herring & Co

ADDRESS 2008 Greens

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59750

CERTIFICATE OF DEATH.

92 D 59750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 N. Kenwood Ave ST., 7 WARD)

2-FULL NAME Nellie M. Becker

(a) RESIDENCE NO. 603 N. Kenwood ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Becker

6 DATE OF BIRTH (month, day, and year) Sept. 30th 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Govt Hill Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Henry Brine

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nancy R. Tagg

13 BIRTHPLACE OF MOTHER (city or town) Balto Co. (State or country) Maryland

14 Informant Henry Becker

(Address) 603 N. Kenwood ave.

15 Filed Dec 28 1921 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1921, to Dec. 26, 1921, that I last saw her alive on Dec 26, 1921, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Chait M. D.

Dec 27 1921 (Address) 701 N. Kenwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hiss Cemetery	Dec 29th 1921
20 UNDERTAKER	ADDRESS
Frank Lassahn Sons	Fullerton Md.

GE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D 59751

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59751

CERTIFICATE OF DEATH.

1 8 2

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Agnes Hospital ST.: 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Bruno

(Residence in Baltimore: No. 803 Myles. St.: yrs., 17 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, December 18, 1893
(Month) (Day) (Year)

7-AGE, 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Bruno

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Magdalena Veninno

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Ann Rocco

(Address) 305 S. Aisquith

15-

Dec 28, 1921, 191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach by Peptic Ulcer

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

12-28-1921 (Address) 412 E. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents Cem

DATE OF BURIAL, Dec 28 1921

20-UNDERTAKER Wendell & Lippold

ADDRESS 1 E Lanvale St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59752

CERTIFICATE OF DEATH.

50 D 59752

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1337 W. Lombard ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor A. Lamkin

(a) RESIDENCE. No. 1337 W. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: James J. Lamkin

6 DATE OF BIRTH (month, day, and year): Sept 28, 1851

7 AGE: Years 70 | Months 2 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Penna

PARENTS

10 NAME OF FATHER: Patk. Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Elizabeth Tiffels

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Howard C. Lamkin
(Address) 1337 W. Lombard St

15 Filed Dec 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921, to Dec 27, 1921, that I last saw h~~e~~r alive on Dec 27, 1921, and that death occurred, on the date stated above, at 7.35 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. Thrs.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill, M. D.

12/27, 1921 (Address) 108 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: Dec 29 1921

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59753

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1452 William ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Gerke

(a) RESIDENCE. NO. 1452 William ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Gerke

6 DATE OF BIRTH (month, day, and year) Sept. 27 - 1827

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	94	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jno. Geake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Jno Loraeffer (Address) 1452 William St

15 Filed 12-29-21 Robert P. Harrison, Registrar

C 281971

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27 1921

17 I HEREBY CERTIFY, That I attended deceased from 1911, 19..., to 12-27, 1921, that I last saw her alive on 12-27, 1921, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical analysis Urine

(Signed) Philip B. Fowler M. D.

12-28, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	12/30 1921
20 UNDERTAKER	ADDRESS
I. Few McCully	730 E. Fort

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of NATURE A-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59754

28 D 59754

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Herbert St. ST., 15 WARD)

2-FULL NAME Lelia Gillespie

(a) RESIDENCE No. 2125 Herbert St. ST., ... WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank S. Gillespie

6 DATE OF BIRTH (month, day, and year) Oct. 24th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville
(State or country) Md.

PARENTS

10 NAME OF FATHER William E. Nagle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Frank S. Gillespie
(Address) 2125 Herbert St.

15 Robert F. Harrison,
Burial Permit Clerk. Registrar

DEC 28 1921 .19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27th 19 21

17

I HEREBY CERTIFY, That I attended deceased from Aug. 19 21 to Dec. 27 19 21.

that I last saw her alive on Dec. 27 19 21,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) P. H. Cradlebaugh, M. D.

Dec 28 19 21 (Address) 2707 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec 30 19 21
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Bal. St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and old state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 28 1921 Burial Permit Clerk. Registrar Joseph B. Cook 1003 N. Bolton St

CHARLES L. HAY

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59755

CERTIFICATE OF DEATH.

80

D 59755

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1333 N. Gilmor St. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Hay

(Residence in Baltimore: No. 1333 N. Gilmor St. St.; yrs., 7 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, May 3, 1864
(Month) (Day) (Year)

7-AGE, 57 yrs. 7 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Mfg

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George W. May

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John A. Dunn

(Address) 1333 N. Gilmor St.

15-

Filed....., 191..... Robert F. Harrison, Registrar.

DEC 28 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 27th 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. C. J. Hennessy M. D.
(Coroner.)

Dec. 27th, 1921. (Address) 2802 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec. 29, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59756

CERTIFICATE OF DEATH.

D 59756

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S. Archer ST., 21 WARD)

2-FULL NAME Gladys Scroggins

(a) RESIDENCE NO. 504 S. Archer ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb, 25, 1907

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
14	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Maryland,

PARENTS

10 NAME OF FATHER: Mossan Scroggins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bruce Wilkerson Co Virginia

12 MAIDEN NAME OF MOTHER: Edna Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va. Co, Maryland

14 Informant: Mossan Scroggins

(Address): 504 S. Archer St

15 Filed DEC 29 1921 ROBERT S. KRAUTER, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/26 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct, 5, 1921, to Dec, 26, 1921,

that I last saw her alive on Dec, 24, 1921,

and that death occurred, on the date stated above, at 9,45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) Wm. Townsend, M. D.

12/27 1921 (Address) 1111 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Broadneck, A. A. Co. Md	Dec 29, 21
20 UNDERTAKER	ADDRESS
John H. Toadvine	1412 Utrill St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mayers.

D 59757

Spec. 5-9-19 H. P. Co.—1000 Bks.

D 59757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Oliver ST.: 23 WARD)

2-FULL NAME Nancy Mayers

(a) RESIDENCE. NO. 1116 Oliver ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ ~~or~~ WIFE of Robert Mayers

6 DATE OF BIRTH (month, day, and year) [illegible] 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pikto.

PARENTS

10 NAME OF FATHER Peter Shay

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible] S. C.

12 MAIDEN NAME OF MOTHER Minnie Shaggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Robt. Mayers (Address) 1116 Oliver St

15 Filed DEC 29 1921 ROBERT R. KRAUTER, Registrar Burial Permit Bureau

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1921, to Dec 26, 1921, that I last saw h[illegible] alive on Dec. 26, 19..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Ac Pneumonic Exhaustion

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Wm A Weymouth, M. D.

Dec 28, 1921 (Address) 1106 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 29 1921
20 UNDERTAKER John H. Jordan	ADDRESS 142 Uhler St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59758

CERTIFICATE OF DEATH.

154

D 59758

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 E. Centry ST.: 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Wells

(Residence in Baltimore: No. 7 E. Center St.: 3 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Nov. 17 [illegible], 1841
(Month) (Day) (Year)

7-AGE. 80 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Naval Officer

9-BIRTHPLACE, (State or Country) Ft. St Louis Mo.

PARENTS.

10-NAME OF FATHER, Henry S. Wells.

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Margaret C. Bier

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jacob. Bier Wells.

(Address)..... 1323 Park ave.

DEC 29 1921

Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 24 1921 to Dec 26 1921 that I saw h[illegible] alive on Dec 26 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) (?) yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardio Sclerosis

(Duration) (?) yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

Dec 27, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holl[illegible]mount Cem

DATE OF BURIAL. 12-29, 1921

20-UNDERTAKER Henry Jenkins Sons Co

ADDRESS [illegible] Richard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59759 — 9V D 59759

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Jhp. Gen. Hosp. ST. 25 WARD)

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Check

(Residence in Baltimore: No. 1111 Sefton St, Hamed Park St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ... (Month) Nov. (Day) ....., 1865 (Year)

7-AGE, 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Salesman
(b) General nature of industry, business, or establishment in which employed (or employer), Cloth

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, Leon Check

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Kendler

(Address) 1111 Sefton St

15- Filed DEC 29 1921, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Dec. (Day) 27, (Year) 1921.

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....., yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Kennedy M. D. (Coroner.)

Dec. 29, 1921 (Address) 302 Equitable Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem — DATE OF BURIAL, Dec 29. 1921

20-UNDERTAKER John J Cowan & Son per Frank Hoglund — ADDRESS 901 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59760

CERTIFICATE OF DEATH.

40 D 59760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Ashburton ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Gilchriest

(a) RESIDENCE NO. 1113 Ashburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer (Day)

(b) General nature of Industry, business, or establishment in which employed (or employer): O'Donnell

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Gilchriest

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Mc Dermot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Mary Brand

(Address) 1113 Ashburton St

15 Filed DEC 29 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1921, to Dec 27, 1921,

that I last saw him alive on Dec. 25th, 1921,

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus

(duration) ? yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray - Oesophagoscopy

(Signed) Walter E Grempler, M. D.

19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Dec, 30 1921

20 UNDERTAKER: James Dizon & Son.

ADDRESS: 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59761 ✓ 78 D 59761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 N. Madeira St.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Crowas

(Residence in Baltimore: No. 928 N. Madeira St.; 20 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Oct (Month) 6 (Day), 1867 (Year)

7-AGE,	If LESS than 1 day,
54 yrs. 2 mos. 21 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Earl Crowas

(Address) 928 N Madeira St

15- Filed DEC 29 1921, 191... ROBERT R. KRACTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-25 1921, to 12-27 1921, that I saw her alive on 12-27 1921 and that death occurred, on the date stated above, at 100 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 da.

(Signed) W. Ruzicka M. D.

12-27 1921 (Address) 800 Matt. Blvd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	Dec 30 1921

20-UNDERTAKER	ADDRESS
Peter Nicolaus	2046 East St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

59762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59762

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Pulson Jr.

(a) RESIDENCE. NO. 1053 Dragon Alley ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George Pulson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Fanny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mercy Hosp Records

(Address)

15 Filed DEC 29 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1921, to Dec 28, 1921, that I last saw h. i. alive on Dec 28, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

8 DAYS

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Eugene Crumpton

(Signed) Benj L Elder M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Dem.

DATE OF BURIAL: Dec 30 1921

20 UNDERTAKER: David Easton

ADDRESS 916 Penna ave

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—1-10-21—M&T—1500 Bks.

D 59763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59763

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 Bendle ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Wilson

(a) RESIDENCE NO. 215 Bendle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucie Wilson

6 DATE OF BIRTH (month, day, and year) May 14th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Elijah Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Tupton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lucie Read

(Address) 215 W. Bendle

15 Filed DEC 29 1921, 19 ..... Registrar

ROBERT R. KRAMER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/26 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/20 1921 to 12/26 1921.

that I last saw h— alive on 12/26 1921

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cumberland

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A. Lee Elliott, M. D.

(Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Queen Town Md.	Dec 30 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Shannon

D 59764

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 Grafton Hospital ST.) 26 WARD)

REGISTERED No. C 1921 D 59764

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Shannon

(Residence in Baltimore: No. 1005 S. Bouldin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	M.

6-DATE OF BIRTH, June (Month) 1 (Day), 1898 (Year)

7-AGE, ... yrs. 5 mos. 27 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship Loftsman
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER. James Maris Shannon Sr.

11-BIRTHPLACE OF FATHER (State or Country). Balto, Md

12-MAIDEN NAME OF MOTHER Elizabeth Keefer

13-BIRTHPLACE OF MOTHER (State or Country). Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie R. Keefer

(Address) 1005 S. Bouldin St.

15- FILED DEC 29 1921 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock

by auto (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) J. Kirk Insley M. D.
(Coroner)

12-29-1921 (Address) 4 E. Lex. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Trinity cem.	Jan 1, 1922
20-UNDERTAKER	ADDRESS
Zickler & Zickler	1739 E. Eager St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

59765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 59765

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 839 Columbia Ave

CITY OF BALTIMORE: (No. Emma Walters ST.: 71 WARD)

2-FULL NAME Emma M. Walters

(a) RESIDENCE. NO. 839 Columbia Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant John Walter

(Address) 839 Columbia Ave

15 Received DEC 29 1921 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 24 1921, to Dec 28, 1921

that I last saw her alive on Dec 28, 1921,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

aorta dilitation of heart

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Grave Foramen Otale

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Laurence Mitchell M. D.

, 19 (Address) Lakeland, Lansdowne P.O.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rodeemer	Dec 30 1921
20 UNDERTAKER	ADDRESS
Ford Grantham	1916 Carlton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Prime

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59766

CERTIFICATE OF DEATH.

64 D 59766

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 McDonough St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E Prime

(a) RESIDENCE. NO. 1029 McDonough St. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 42 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry C Prime

6 DATE OF BIRTH (month, day, and year) June 3 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Reginald Von Haleen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Dorothea Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Mabel Prime (Address) 1029 McDonough St

15 Filed ....., 19..... Registrar

DEC 29 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921 to Dec 26, 1921.

that I last saw h alive on Dec 21, 1921.

and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis -

(duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical exam

(Signed) H. H. Thomas M. D.

(Address) 2228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dalto Cemetery	Dec 29 1921

20 UNDERTAKER Robt J Turner ADDRESS 1442 N. Fulton Ave.

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 59767

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 N. Bond ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Ward

(a) RESIDENCE NO. 1327 N. Bond ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sophie Ward

6 DATE OF BIRTH (month, day, and year) Feby 7th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 043

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER George Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Cecil Co Md

12 MAIDEN NAME OF MOTHER Susie Richard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Mrs Sophie Ward
(Address) 1327 N. Bond st

15 Filed DEC 29 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 . 1921 . to Dec 28 . 1921 .

that I last saw him alive on Dec 27 . 19 .

and that death occurred, on the date stated above, at 12.20a m.

The CAUSE OF DEATH* was as follows: Acute Bright's Disease

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo S. Young, M. D.

Dec 28 1924 (Address) 1107 Lexington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 30th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition. No further history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59768

59768

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 1633 McElderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Downs

(a) RESIDENCE. NO. 1633 McElderry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Luke Downs

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 31 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of Industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C. Has been in Baltimore 4 years

PARENTS

10 NAME OF FATHER Sandy Blue

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Forgetta Macmillen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) Luke Downs (Husband) 1633 McElderry At Balto

15 Filed ..., 19... ROBERT R. KRAUTER, Registrar

DEC 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1921, to Dec 28, 1921, that I last saw her alive on Dec 27, 1921, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Lab

(Signed) R J Young, M. D.

19 (Address) 1429 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount-Rose N C — DATE OF BURIAL: December 31 1921

20 UNDERTAKER: Wm Robert & Elliott — ADDRESS: 1735 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59769

CERTIFICATE OF DEATH.

28

D 59769

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Carlisle Place ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margie Chambers

(Residence in Baltimore: No. 1721 Carlisle Place St.; 17 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 31 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

9-BIRTHPLACE, (State or Country), Green Bay Va
live in Baltimore 17 years

PARENTS.

10-NAME OF FATHER, William Scott

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Chambers
(Address) 1721 Carlisle Place

15-

Filed DEC 29 1921 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 1921, to Dec 26 1921, that I saw her alive on Dec Dec 21 1921, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 1 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Stenosis

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) C. H. Frank M. D.

Dec 27 1921 (Address) 712 S. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Bay Va

DATE OF BURIAL, Dec 28, 1921

20-UNDERTAKER Jones Retail - A Elliott

ADDRESS 1725 Eastland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59770

CERTIFICATE OF DEATH.

91 D 59770

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital (St.:) 21 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James K. Hamlin

(a) RESIDENCE. NO. ~~Unknown~~ 512 Ottenbein ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Male	White	Unknown Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 5 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 667

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER James M. Hamlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Susan R. Peck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Hospital Records, Municipal Hospital.

15 DEC 29 1921 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from December 16. 1921. to December 28. 1921. that I last saw him alive on December 27. 1921. and that death occurred, on the date stated above, at 7:05 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Aut

(Signed) Clyde Mowell, M. D.

12/29/21 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park — DATE OF BURIAL Dec 30 1921

20 UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1200 59771

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Roland Ave near Lake Ave ST.: Roland Park WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia A Stevenson

(a) RESIDENCE. NO Kingston N C ST. WARD. Virginia N.C.

(Usual place of abode) (If nonresidents give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Stevenson

6 DATE OF BIRTH (month, day, and year) April 15 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER Joel A Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Martha Kornegay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant J J Stevenson (Address) Kingston N C

15 Date DEC 29 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1921, to Dec 29, 1921, that I last saw h[illegible] alive on Dec. 29, 1921, and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore F. Morrison, M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kinston N. C	Dec 29 1921
20 UNDERTAKER Henry H Adkins & Co	ADDRESS Oakland No 6 Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59772

CERTIFICATE OF DEATH.

GN

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Lawrence

(a) RESIDENCE. No. 829 Whatcoat St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Albert Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Betsy Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Mercy Hosp. Records

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): DEC 28 1921

17 I HEREBY CERTIFY, That I attended deceased from DEC 23. 1921. to DEC 28. 1921.

that I last saw him alive on DEC 28. 1921.

and that death occurred, on the date stated above, at 10:35 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Lower left lobe).

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Acute Pulmonary Edema (duration) yrs. 3½ hours mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) John L. Cowin, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	DEC 31 1921
20 UNDERTAKER	ADDRESS
Sam'l N. Chase & Son	1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59773

D 59773

CERTIFICATE OF DEATH.

X 168-003

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. 14 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Geneva~~ Geneva Klingle

(a) RESIDENCE NO. Aberdeen Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11. 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benj H. Klingle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lizzie Ratliff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant B.H. Klingle (Address)

15 Filed DEC 29 1921 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec 28 . 1921. to Dec 29 . 1921.

that I last saw h alive on Dec 29 . 1921.

and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Ether anesthesia for Tonsil Operation. (Corr)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Status Lymphaticus ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 29, 1921.

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E E Duncan, M. D.

12/29, 1921 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md. — DATE OF BURIAL: 12/29 192

20 UNDERTAKER: Wm. J. Lichnert Son — ADDRESS: Light Aberdeen Md

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 59774

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 519 n Caroline St.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lee

(Residence in Baltimore: No. 519 n Caroline St.: yrs., 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... Jan. (Month) ..... 19 (Day), 1843 (Year)

7-AGE, 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Owen Oliver

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Louise Oliver

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie E. Emery

(Address) 519 N. Caroline St.

15- Robert F. Harrison,

Filed ....., 191.....

DEC 29 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) ....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) Kirk Bowles M.D.
(Coroner)

12-28, 1921 (Address) 4 E. Lex. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Rotond Cemetery — DATE OF BURIAL, Dec 30th, 1921

20-UNDERTAKER, Chas G. Bailey — ADDRESS, 1742 Madison Ave

D 59775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59775

CERTIFICATE OF DEATH.

168 001

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 5 N Hanover ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew J. Miller

(Residence in Baltimore: No. 5 N Hanover St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	white	Single

6-DATE OF BIRTH. April (Month) 31 (Day), 1903 (Year)

7-AGE. 18 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... U. S. Navy

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Henry Miller

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Barbara Langbein

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Miller

(Address) 5 N. Hanover St.

15- Robert M. Harrison, Registrar.

DEC 29 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia. Drowning

Gas. Prob. Work accident (Duration) yrs. mos. ds. Presumed

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hart Smith M. D.
(Coroner)

12-29-1921 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec. 30, 1921
20-UNDERTAKER Lilly and Zeh	ADDRESS 403 S. Wolfe St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59776

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59776

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St. Josephs Hospital St.: V WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm R Dinsmore

(a) RESIDENCE. No. 608 S. Regester St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Dinsmore

6 DATE OF BIRTH (month, day, and year) Sept 1, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58.	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Dinsmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Nellie Dinsmore

(Address) 608 S. Regester St

12 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1921

17 I HEREBY CERTIFY, that I attended deceased from Dec 22, 19 21, to Dec 26, 19 21, that I last saw him alive on Dec 26, 19 21, and that death occurred, on the date stated above, at 8 .m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Larynx.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) F. C Mannon, M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cem.	Dec 30 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Fleet St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 29 1921 Robert F. Carter

Spec.—1-10-21—M&T—1500 Bks.

D 59777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59777

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Elliott ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cinderella Walter

(a) RESIDENCE NO. 2912 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph L. Walter

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover Pa.
(State or country)

PARENTS

10 NAME OF FATHER Joshua W. Lynch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah De. Groff

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Joseph L. Walter
(Address) 2912 Elliott St.

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1921, to Dec 27, 1921, that I last saw he alive on Dec 27, 1921, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis with Valvular defect, unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dilated heart (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. McCamy, M. D.

1921 (Address) 839 S. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Dec. 31 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Madison Ave

DEC 29 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

(Geruve)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59778

CERTIFICATE OF DEATH.

175 '04 D 59778

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Hopkins Hosp'l ST.: WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josh. Gerve

(Residence in Baltimore: No. 2612 Orleans St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word) Married

6-DATE OF BIRTH, Feb. (Month) 22 (Day), 1857 (Year)

7-AGE, 64 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Gerve

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Gerve

(Address) 2612 Orleans St

15- Dec 29 1921 Robert P. Harrison, Burial Permit Clerk, 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism fr by Ulcus carc. colli uteri

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Wiley M. D.
(Coroner)

12-28-21 (Address) 4 E. Lex. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Paul's Cem. DATE OF BURIAL, Dec. 30 1921

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Eutaw St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59779

D 59779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2828 Harford Ave ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward N. Rice

(a) RESIDENCE. No. 2828 Harford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
~~HUSBAND~~ of
~~or, WIFE~~ of Ida Rice

6 DATE OF BIRTH (month, day, and year) Oct 5 - 1883 -

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	2	23	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) machinery

(c) Name of employer T St Clr Brand.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nicholas Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Wehner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida Rice
(Address) 2828 Harford Ave

15 Filed 19 Robert F. Harrison, Registrar

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1921, to Dec 28, 1921, that I last saw him alive on Dec 28 -, 1921, and that death occurred, on the date stated above, at 6:05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) G E Burton, M. D.

12/29 1921 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 31 1921
20 UNDERTAKER	ADDRESS 1034
B Schloman Son	Fayette

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59780

92 D 59780

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Barclay ST., 17 WARD)

2-FULL NAME Nannette Rausch

(a) RESIDENCE NO. 1723 Barclay ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick A. Rausch

6 DATE OF BIRTH (month, day, and year) Uniform

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
Uniform 50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) — 069

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Auer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER F. Reichman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Ida Sadler (Address) 2032 Jefferson St.

15 Filed DEC 30 1921 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1921, to Dec 28, 1921, that I last saw her alive on Dec 28, 1921, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. H. Cowen, M. D.

Dec 29, 1921 (Address) 508 E Monument ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 12/31/21

20 UNDERTAKER Wm Cook — ADDRESS 502 E. North ave

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59781

HEALTH DEPARTMENT—CITY OF BALTIMORE

109 D 59781

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospital ST.; 127 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Bowen

(Residence in Baltimore: No. 72 Cuthbert St; St.; (yrs., 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 10 (Day), 1899 (Year)

7-AGE, 22 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Painter (b) General nature of industry, business, or establishment in which employed (or employer) N/A

9-BIRTHPLACE, (State or Country). Hampstead Md.

PARENTS.

10-NAME OF FATHER, Henry B Bowen

11-BIRTHPLACE OF FATHER (State or Country). Hampstead Md

12-MAIDEN NAME OF MOTHER Cora Beulle

13-BIRTHPLACE OF MOTHER (State or Country). Hanover Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry W Bowen

(Address) 72 Cuthbert St.

15- Filed DEC 30 1921 ROBERT R. KRAUTER, Burial Permit Clerk. 191 Registrar.

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. Physician should sign and return certificate promptly. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1921, to Dec 28 1921, that I saw him alive on Dec 28 1921, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) ....yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) H C Worblick M. D.

Dec 28 1921 (Address) Franklin Sq Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). In the State ....yrs. [redacted] ds. At place of death ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 72 Cuthbert St.

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, 12/31, 191..

20-UNDERTAKER Wellman Co 16 ADDRESS 502 E Mt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59782

CERTIFICATE OF DEATH.

79 D 59782

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 90 Light St. (St.) 23 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Ruppel

(a) RESIDENCE. No. 90 Light St St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widowed

6 DATE OF BIRTH (month, day, and year): June 29 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: George Hulfinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dk.

14 Informant: Mrs. J. Edw. Koob

(Address) 90 Light St.

15 Filed DEC 30 1921 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/28 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/1, 192, to 12/28, 1921, that I last saw her alive on 12/27, 1921, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Organic Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edw. Bruch, M. D.

Dec 29 21 (Address) 90 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Park Cemetery	Dec 30 1921
20 UNDERTAKER: John F. Denny	ADDRESS: 715 Light St

CAUSE OF DEATH in plain terms. Abbreviations not to be used. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59783

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 704 N. Carey ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Grey Mason

(a) RESIDENCE. NO. 704 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs. Edith E. Mason

6 DATE OF BIRTH (month, day, and year) Apr. 22-1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55-	8	5	

8 OCCUPATION OF DECEASED Supt. of 086

(a) Trade, profession or particular kind of work Paper Box Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer) Paper Box Factory

(c) Name of employer Chas. J. Taylor & Co.

9 BIRTHPLACE (city or town) (State or country) Middlesex Co. Va.

PARENTS

10 NAME OF FATHER Miles F. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ida Tefft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Miles P. Mason
(Address) 704 N. Carey St

15 DEC 30 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27- 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21- , 1921, to Dec. 27- , 1921, that I last saw him alive on Dec. 27- , 1921, and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) - yrs. - mos. 6 ds.

CONTRIBUTORY (Secondary) Later Pneumonia

(duration) - yrs. - mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 906 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 30 192
20 UNDERTAKER John F. Deany	ADDRESS 715 Lights

CAUSE OF DEATH in plain terms, so that a layman can understand. See instructions on back of certificates. TION is very important.

[illegible] UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous pleurisy.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59784

091

40 D 59784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wilson

(a) RESIDENCE. NO. 238 Pearl st. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	✓	✓	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber 059
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Trenton, N. Jersey.

PARENTS

10 NAME OF FATHER Woodell Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Crosswicks N. Jersey.

12 MAIDEN NAME OF MOTHER Liza Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Penn

14 Informant (Address) Office & Clinical Records.

15 Filed . 19 Registrar

ROBERT R. KRAUSE
DEC 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28 1921.

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to Dec- 28, 1921.
that I last saw him alive on Dec- 28, 1921.
and that death occurred, on the date stated above, at 8:45 p m.
The CAUSE OF DEATH* was as follows:
Septic Broncho-Pneumonia

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Carcinoma oesophagus
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 10/20/21
Was there an autopsy?
What test confirmed diagnosis? Clinical Findings
(Signed) Cyrus F. Hahn, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	Dec 31st 1921
20 UNDERTAKER	ADDRESS
A Jones	207 E. Lanvale st

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59785

CERTIFICATE OF DEATH.

50 D 59785

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 N Ann St ST., 6 WARD)

2-FULL NAME Hyman GLASER

(a) RESIDENCE NO. 102 N Ann St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Glazer

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing 080

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rueben Glaser
(Address) 102 N Ann St

15 Filed DEC 30 1921 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1921, to Dec 6, 1921, that I last saw ~~he~~ alive on Dec 6, 1921, and that death occurred, on the date ~~stated above~~, at 2 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Diabetes

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 10? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No - Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maurice Feldman M. D.

Dec 30, 1921 (Address) 1806 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Herring Run	12/30 1921

20 UNDERTAKER Jack Lewis ADDRESS 1440 E Balto St

CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See instructions on back of certificates. TION is very important.

(See affidavit over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59786

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 59786

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 6 WARD)

2-FULL NAME Mrs. Bessie Friedman

(a) RESIDENCE. NO. 441 N. Patterson Park Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Isaac Friedman

6 DATE OF BIRTH (month, day, and year) ~~Dec 2 1873~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48.	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ella Kurz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mercy Hosp. Records (Address)

15 Filed DEC 30 1921 Registrar

ROBERT R. KRAUTER
Chief Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1921, to Dec 29, 1921, that I last saw h'r alive on Dec 29, 1921, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy (duration) 33½ hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & Symptoms

(Signed) John J. Eaton, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 12-30- 1921

20 UNDERTAKER Park Lewis, 1411 E Balto

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or initials. Do not write on back of certificates. INFORMATION is very important. See instructions on back.

BALTIMORE, MD., January 10th, 1922

D59786

Health Department,

City of Baltimore.

State of Maryland.

Gentlemen :-

This is to certify that on December the 29th, 1921, I signed a death certicate for the Late Bessie Freidman, and the age given on death certicate was 55 years whereas it should had been 48 years. The age of 55 years was given to me at the time of great distress.

John J. Erwin, M.D.

State of Maryland

City of Baltimore

This is to certify that on January the 10th, 1922 personally appeared Dr. John J. Erwin, and made oath in due form of law, that the above statement is true and bona-fide to the best of his knowledge and beleif.

Sadie M. Luena
Notary Public

SEAL

my commission expires May 1st, 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

Vincent Citarella

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 53 D 59787

D 59787

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Howard A Kelly Hospital Inc. 1418 Eutaw Place ST. 14 WARD)

2-FULL NAME Mr. Vicente Citarella

(a) RESIDENCE. NO. Howard A. Kelly Hospital ST., WARD. Habana Cuba
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Juana C. de Citarella Sept 14 1896

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marble Merchant 045
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italia

PARENTS

10 NAME OF FATHER Joe Citarella

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italia

12 MAIDEN NAME OF MOTHER Cayetana

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italia

14 Informant Mrs Juana C. de Citarella (Address) Habana Cuba

15 DEC 30 1921 ROBERT P. ... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Dec 29, 1921, that I last saw him alive on Dec 29, 1921, and that death occurred, on the date stated above, at 10 55 A.m.

The CAUSE OF DEATH* was as follows:
Hodgkins Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No Excised
What test confirmed diagnosis? Microscopic exam'n'd
(Signed) Dudley A Kobuta M. D.
(Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Habana Cuba

DATE OF BURIAL Dec 31 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

59788

HEALTH DEPARTMENT—CITY OF BALTIMORE

59788

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3408 Morton Ave ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Brown Thomas

(a) RESIDENCE. No. 3408 Morton Ave ST., Howard Park WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frisby F. Thomas

6 DATE OF BIRTH (month, day, and year) Dec 10 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Eugene T. Bygane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portsmouth Va.

12 MAIDEN NAME OF MOTHER Eliza D. Mosely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Frisby F. Thomas

(Address) 3408 Morton ave

15 Filed DEC 30 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct ....., 1920, to Dec 28th, 1921, that I last saw h alive on Dec 27th, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vulva and inguinal glands

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 1920

Was there an autopsy? No Dec 1921.

What test confirmed diagnosis? Microscopical

(Signed) A. C. Summers, M. D.

(Address) 4209 Eldrid Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec 30 1921

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be understood by persons in all parts of the country. Information required in items 16 to 20 inclusive must be given by the attending physician. See instructions on back of certificates. TION is very important.

DEC 30 1921 ROBERT R. KRAMER Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59789 105 D 59789

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1545 Pennsylvania Ave ST 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Ford

(Residence in Baltimore: No. 1545 Pennsylvania ave. St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	colored	widow

6-DATE OF BIRTH. ....., 1880
(Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER Henry Minton

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Daisy Kum

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lina Freeman

(Address) 1545 Penna. ave.

15- Filed DEC 30 1921 191 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute dilatation of heart
5 hours
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Ac. Lobar pneumonia
(Duration) ..... yrs. ..... mos. 1 hr. ..... ds.
(Signed) J. T. Finnegan M. D.
(Coroner.)
Dec. 29. 1921 (Address) 802 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec. 31, 1921.

20-UNDERTAKER Jesse D. Lewis — ADDRESS 713 Eutaw

N. B. Every item of information must be given in plain terms, so that it may be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Ball.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59790

42 D 59790

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Angle ST., 14 WARD)

2-FULL NAME Martha Ball

(a) RESIDENCE NO. 1525 Angle ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Ball

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years 52 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED Domestic 037

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) Household

(c) Name of employer .....

9 BIRTHPLACE (city or town) Lancaster Co
(State or country) Pa

PARENTS

10 NAME OF FATHER Leonard Webster

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Kirkman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Ida Smith
(Address) 1525 Angle

15 Filed DEC 30 1921 ROBERT R. KRAUTH Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Dec 28, 1921, that I last saw h.. alive on Dec 28, 1921, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus
9 mo's duration

(duration) 9 mo's yrs. mos ds.

CONTRIBUTORY
(Secondary) .....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. Gabriel Thompkins M. D.

(Address) 1534 E. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL Dec 30 1921

20 UNDERTAKER James H. Davis

ADDRESS 1303 Greenmount

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. Fill in all items on back of certificates. TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59791 ✓ D 59791

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3762 Marley ST.: 70 WARD)

2-FULL NAME Wilbur F Mentka

(a) RESIDENCE. NO. 3762 Marley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 13-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Bait. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Edw. F. Mentka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Elizabeth Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Edw F. Mentka (Address) 3762 Marley Ave

15 Filed DEC 30 1921, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1920, to Dec 28, 1921, that I last saw him alive on Dec 28, 19—, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 30 19 21

20 UNDERTAKER: F. B. Keppert — ADDRESS: 2236 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be understood by all. Every question must be answered. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59792

CERTIFICATE OF DEATH.

150

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1704 N. Monroe (ST.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eloise Eunice Bland

(a) RESIDENCE. (No.) 1704 N. Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1704 N. Monroe St. Baltimore Md.

PARENTS

10 NAME OF FATHER Henry E. Bland

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emily Hannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Emily Bland (Address) 1704 N. Monroe St

15 Filed DEC 30 1921 H.E. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1921, to Dec. 29, 1921, that I last saw h[illegible] alive on Dec. 29, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

0 042

Status Lymphaticus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms

(Signed) J. F. Hanahan, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 30 1921
20 UNDERTAKER	ADDRESS
Martin Fahey Son	1837 Wash Blvd

IMPORTANT—Fill out CAUSE OF DEATH in plain terms. Spelling on back of certificates. CAUSE OF DEATH is very important. See instructions on back TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital condition

Spec.—1-10-21—M&T—1500 Bks.

Herr.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59793

D 59793

CERTIFICATE OF DEATH.

9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1005 S. Paca. ST., 21 WARD)

2-FULL NAME James Wm. Herr

(a) RESIDENCE NO. 1005 S Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced) HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo J Herr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Clara Bafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mother Clara Herr

(Address) 1005 S Paca St

15 Filed DEC 30 1921 J H Kehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17

I HEREBY CERTIFY, That I attended deceased from 12-29 1921 to 12-29 1921.

that I last saw him alive on 12-29 1921,

and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diptheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Schwamm M. D.

12-29 1921 (Address) 1120 W Lewis St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL 12-30 1921

20 UNDERTAKER James Digman & Son

ADDRESS 1000 E Pratt St

mation should be ... CAUSE OF DEATH in plain terms, so that ... TION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

James O. Carter

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59794

CERTIFICATE OF DEATH.

640 59794

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 519 Bloom h St. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James O Carter

(a) RESIDENCE. NO. 519 Bloom ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Jas O Carter

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: 57 (Years / Months / Days) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Solomon Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Iva Randolph (Address) 519 Bloom St

15 Filed DEC 30 1921 19 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1921 to Dec 27 1921, that I last saw h alive on Dec 27 1921, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy + Paralysis

(duration) yrs. 13 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Rbutler, M. D.

12/27 1921 (Address) 2134 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Auburn — DATE OF BURIAL: Dec 30 1921

20 UNDERTAKER: Saml T Hemsley — ADDRESS: 5720 Riddle

IMPORTANT—Fill in plain terms, so that CAUSE OF DEATH can be readily understood. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59795

CERTIFICATE OF DEATH.

92 D 59795

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2015 Homewood Ave ST. 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M Naughton

(Residence in Baltimore: No. same St.; 44 yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb (Month) 11 (Day), 1877 (Year)

7-AGE, 68 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Christopher Fitzgerald

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Carney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph L Naughton

(Address) 2015 Homewood Ave

15- DEC 30 1921 Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CAUSE OF DEATH in plain terms. important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-28 1921, to 12-29 1921, that I saw h[illegible] alive on 12-28 1921, and that death occurred, on the date stated above, at 5 10 a m.

The CAUSE OF DEATH* was as follows:

Intra Cranial

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward C Morgan M. D.

12-29, 1921 (Address) 1322 Harlem

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Texas Balto Co

DATE OF BURIAL, Jan 2, 1922

20-UNDERTAKER E A Wingfield Jr

ADDRESS 501 E 22 St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59796

CERTIFICATE OF DEATH.

137 59796

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Sienkielewski

(a) RESIDENCE. No. 508 S. Broadway ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Sienkielewski

6 DATE OF BIRTH (month, day, and year) Oct 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Sienkielewski (Address) 508 S Broadway

15 Filed DEC 30 1921 ROBERT R. KRAUT Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28 . 1921 . to Dec 29 . 1921 . that I last saw her alive on Dec 29 . 1921 . and that death occurred, on the date stated above, at 7:50 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo. R. Wilding . M. D.

. 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 31 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms. No abbreviations or terms of doubtful meaning. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 59797

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Cross St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celeste. Mc. Gowan

(a) RESIDENCE. No. 1213 W Cross St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 26. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Bernard Mc. Gowan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Monahan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Dr Bernard Mc. Gowan

(Address) 1213 W Cross St

15 DEC 30 1921 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 . 1921 . to Dec 29 . 1921 .

that I last saw her alive on Dec 29 . 1921 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine (Potts Disease) 2 weeks

Intestinal Indigestion (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Convulsion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw. V. Coleman, M. D.

, 19 (Address) 24 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Dec 31st, 1921

20 UNDERTAKER John J. Gowan & Son

ADDRESS 901 N. Howard St

N. B.—Information should be carefully written, in terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59798

CERTIFICATE OF DEATH.

39

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1358 Columbia Ave ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Quinn

(a) RESIDENCE. (Usual place of abode) No. 1358 Columbia Ave ST.. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m	w	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delia Nester Quinn

6 DATE OF BIRTH (month, day, and year) Jan 3 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Delia Quinn

(Address) 1358 Columbia Ave.

15 Filed DEC 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10 . 1921 . to Dec 29 . 1921 .

that I last saw him alive on Dec 27 . 1921 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma (tongue)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw. McCahan, M. D.

. 19 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	Jan 2nd, 1922

20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St
per J. J. Cowan.	

ROBERT R. KRAUTER, Burial Permit Clerk.

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-13—H. P. Co.—1000 Blks.

D 59799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59799

X 91

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411-Guilford Terrace ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MIRIAM BALDWIN.

(a) RESIDENCE. No. 3411 Guilford Terrace ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? 0 yrs. 4 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) July-30-1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Pensacola Florida.

PARENTS

10 NAME OF FATHER: William Lester Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chestertown Maryland

12 MAIDEN NAME OF MOTHER: Irene Cecilia Pinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pensacola Florida

14 Informant: W. Lester Baldwin (father)
(Address) 3411-Guilford-Terrace, City.

15 1921 . 19 ..... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1921, to Dec 29, 1921, that I last saw her alive on Dec 29, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Rathrich, M. D.

1924 (Address) 11 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown, Kent Co., Md.

DATE OF BURIAL: Dec-31-21

20 UNDERTAKER: ROBERT E. MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

mation should be given in plain terms, so that it may be understood by the public. CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

(Carrie Hohman) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59800

D 59800

50

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1849 N Broadway ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Hohman

(a) RESIDENCE. NO. 1849 N Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of H. J. Hohman

6 DATE OF BIRTH (month, day, and year) Feb 5 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Henry Jost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Carrie Jost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant H. J. Hohman
(Address) 1849 N Broadway St

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

C 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct-12, 1919, to Dec 29, 1921, that I last saw h er alive on Dec 29, 1921, and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 23 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Unnecessary

(Signed) James R Eisenberger M. D.

12/30, 1921 (Address) 1729 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westview

DATE OF BURIAL: Jan 2 1922

20 UNDERTAKER: H. P. Hannigan Son

ADDRESS 517 N Schroeder St

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

D 59801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59801

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1827 N. Northern ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. E. Fahey

(Residence in Baltimore: No. 1827 N. Northern ave St.; 52 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH, November 5, 1869 (Month) (Day) (Year)

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or mins.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE. (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER. Martin Fahey

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Sarah Corrigan

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Fahey

(Address) 3401 Cathedral Stre

15- Robert P. Harrison, 191 Registrar.

DEC 30 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Dilatation of Heart

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(Duration) 5 yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner)

Dec. 30, 1921 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Cathedral Cem

DATE OF BURIAL. 1/2, 1922

20-UNDERTAKER J. J. Fahey & Son

ADDRESS 3401 Eastern Ave

Every item of information must be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(See affidavit over) V

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59802

CERTIFICATE OF DEATH

D 59802

REGISTERED NO. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Adam Grzegorzewski Curtis Bay, 5

CITY OF BALTIMORE: (No. 7 Cypress St. Brooklyn ST.: 5th WARD)

2-FULL NAME Adam ~~Joseph~~ Grzegorzewski

(a) RESIDENCE. No. 7 Cypress St, Curtis Bay, Balto. Md ST., 5th WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 29 yrs. — mos. —

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of —— Theodorzia Grzegorzewski

6 DATE OF BIRTH (month, day, and year) Dec 24th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman at Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Car & Foundry Co

(c) Name of employer B

9 BIRTHPLACE (city or town) (State or country) Russia, Poland

PARENTS

10 NAME OF FATHER Paul Grzegorzewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia, Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia, Poland

14 Informant Adam J. Grzegorzewski Jr (Address) 7 Cypress St. Curtis Bay, Md

15 Filed —— Robert F. Harrison, Registrar

C 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st 1921. to Dec 27th 1921. that I last saw h in live on Dec 27th 1921. and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) — 1 mos. —

CONTRIBUTORY (Secondary) Heart Failure

(duration) at once

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. B. Horton, M. D.

. 19 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Dec 31st 1921
20 UNDERTAKER	ADDRESS
Margaret Flynn	Balto

mation should be carefully written in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 5980

DR. THOMAS B. HORTON
No. 1 CEDAR STREET
PHONE CURTIS BAY 6

CURTIS BAY, BALTIMORE, MD., Jan 9

I hereby Certify that the pa
referred to in attached
permit was named Adam
Grzegorzeewski, instead of
Adam Joseph Grzegorzeewski -

Thos. B. Horton M.D.
Attending Physician,

On Jan 9th Thos. B. Horton, M.D. appea
before me, and swore the above statement is tru

Anna M. Beguelle
Notary Public

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59803

CERTIFICATE OF DEATH.

79 D 59803

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 Linden Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgie E Lease

(a) RESIDENCE No. 1531 Linden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert E Lease

6 DATE OF BIRTH (month, day, and year): Dec 17 1867

7 AGE: Years 54 Months Days 56

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: George Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Lelia Cracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Suffolk Va

14 Informant (Address): Albert E Lease 1531 Linden ave

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1918, to Dec 29th, 1921, that I last saw her alive on Dec 28th, 1921, and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis + Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1514 Lanvale St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) C E Mortimer M. D.

19 (Address) 1420 Eutaw Pl, City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 12/31/1921

20 UNDERTAKER: William Cut 508 E Balto

ADDRESS

Mark of certificates. mation should be given CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59804

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Shearer

(a) RESIDENCE. NO. St. Joseph's Hospital ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer) Orthopedic Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER John J. Shearer

11 BIRTHPLACE OF FATHER (city or town) Scotland.
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Buckley

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mr. Louis B. Arnold

(Address) 1600 Darley Ave

15 Filed ..... 19 Robert P. Harrison, Registrar

C 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1921, to Dec. 30, 1921, that I last saw him alive on Dec. 30, 1921, and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory S. & P. S.

(Signed) Frank C. Marino, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Jan 5th 1922
20 UNDERTAKER Henry Storck Son	ADDRESS 1301 E. Eager

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it shall be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy Taylor

(a) RESIDENCE. No. 209 Herring Court ST., WARD.
(Usual place of abode) about 20 yrs.
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? Unknown yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Bahama Islands

PARENTS

10 NAME OF FATHER Lional Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bahama Islands

12 MAIDEN NAME OF MOTHER Rosena Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bahama Islands

14 Informant Hospital Records
(Address)

15 DEC 31 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 19 21, to Dec. 29, 19 21, that I last saw him alive on Dec. 29, 19 21, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of larynx

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) Francis L. Dadaglueen, M. D.

12-29-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Dec 31 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E monument

mation should be given in this space. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59806 D 59806

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Mulberry St. St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Henry Nelson

(Residence in Baltimore: No. 1734 Mulberry St St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, Dec 2 (Month) (Day), 1841 (Year)

7-AGE, 50 yrs. — mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER, John Nelson

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Nelson

(Address) 1734 mulberry St

15- Robert P. Harrison,

Filed ....., 191..... Burial Permit Clerk. Registrar.

31 1921

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 1921, to December 28 1921, that I saw h[illegible] alive on Dec 27 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

Tuberculosis

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard L. Barker M. D.

Dec 28 1921. (Address) 1514 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Asbury Cemetery

DATE OF BURIAL. Jan 1 1922

20-UNDERTAKER Joseph E. Farrell

ADDRESS 2314 Dundalk

Spec.—1-10-21—M&T—1500 Bks.

D 59807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59807

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 E Lanvale ST., 8 WARD)

2-FULL NAME Charles L Wise

(a) RESIDENCE NO. 2015 E Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, (Husband or Wife) of Ida L Wise

6 DATE OF BIRTH (month, day, and year) August 21st 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westmoreland Co Va.

PARENTS

10 NAME OF FATHER William Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Shackleford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Ida L Wise

(Address) 2015 E Lanvale st

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from about Dec 10, 1921, to Dec 24, 1921, that I last saw him alive on Dec 29, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia Terminal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Riley, M. D.

, 19 (Address) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Jan 2nd 1922

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

31 1921

Spec.—1-10-21—M&T—1500 Bks.

Dr. Herrman Balto & Carling

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59808

D 59808

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3907 Mt. Pleasant Ave. 26 WARD)

2-FULL NAME William Schubert

(a) RESIDENCE NO. 3907 Mt. Pleasant Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 00

(b) General nature of industry, business, or establishment in which employed (or employer) Baby

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Schubert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margaret Jerscheid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant William Schubert

(Address) 3907 Mt. Pleasant Ave.

15 Filed 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/29/21, 19.., to 1/1/22, 19.., that I last saw him alive on 1/1/22, 19.., and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Colitis Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Herrman, M. D.

, 19 (Address) 1919 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec 31 1921
20 UNDERTAKER	ADDRESS
H. Sunder & Sons	1110 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

Mamie Butz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59809

D 59809

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 736 W. Cross St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Butz

(a) RESIDENCE NO. 736 W. Cross St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John J. P. Martin Butz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Waxmuth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Walter Butz
(Address) 736 W. Cross St.

15 Filed DEC 31 1921 Robert P. Harrison, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29th 19 21

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Dec 29, 1921,

that I last saw h-er alive on Dec 28, 1921,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Greenbaum, M. D.

, 19 (Address) 317 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 31 1921

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 Madison Ave

INSTRUCTIONS. Fill in all blanks on back of certificates. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59810

CERTIFICATE OF DEATH.

D 59810

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3741 Harcourt Road (ST.) (27) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Louise Zink

(a) RESIDENCE. (No.) 3741 Harcourt Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob John deceased

6 DATE OF BIRTH (month, day, and year) July 5, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Zink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria, Germany

12 MAIDEN NAME OF MOTHER Barbara Ohrlhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria, Germany

14 Informant Rev. John G. Fohn (Address) 811 Locust St., Columbia, Pa.

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1921, to December 29, 1921, that I last saw her alive on December 29, 1921, and that death occurred, on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

(Chronic interstitial Nephritis

(duration) yrs. mos. ds.

(Pneumonia (Hypostatic) - Collapse

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) George H. Hoffman, M. D.

(Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	Jan. 1 1922
20 UNDERTAKER	ADDRESS
Louis Hoemann	325 Broadway

C 31 1921

No 1948

CAUSE OF DEATH. See instructions on back of Certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59811

D 59811

92

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. 123 S. 2nd St. Brooklyn ST., 25 WARD)

2-FULL NAME John Oliver Miller

(a) RESIDENCE No. 123 S. 2nd St. Brooklyn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug. 15/21.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Infant X
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay, Balto. Md.

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn Md

12 MAIDEN NAME OF MOTHER Anna O. Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant John Miller
(Address) 123 S. 2nd St. Brooklyn

15 Filed ..... 19 ..... Robert F. Harrison Registrar

C 31 1921 Vital Statistics Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1921, to Dec. 29, 1921, that I last saw him alive on Dec. 29, 1921, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. ... mos 1/2 ds.

CONTRIBUTORY (Secondary) Convulsions 6 hours.
(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Geo. B. Evans, M. D.

12/29, 1921 (Address) 211 Church St. - Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	12-30 1921
20 UNDERTAKER	ADDRESS
E. R. Battarle	115 E. West St.

CAUSE OF DEATH in plain terms. No abbreviations. If unknown, state so. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59812

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Rooney

(a) RESIDENCE. No. Mercy Hospital ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	? 85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mercy Hospital
(Address) City

15 Filed Robert F. Harrison, Registrar
Burial Permit Clerk.

C 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr 15, 1912, to Dec 31, 1921, that I last saw her alive on Dec 31, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) 3 hrs yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms.

(Signed) John J. Ryan, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	1-2 1922

20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

CAUSE OF DEATH to be plain and full, TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59813 D 59813

CERTIFICATE OF DEATH.

X 430

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Greene & Lombard Sts. (St.; Ward) 4

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Diggs

(a) RESIDENCE. No. Uppers. Md. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Diggs

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: About 27 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Josephine Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Andrew Diggs
(Address): Living with D mtd

15 Filed DEC 31 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 30 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1921, to Dec. 30, 1921, that I last saw her alive on Dec. 30, 1921, and that death occurred, on the date stated above, at 8 10 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Septic pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Diffuse peritonitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec. 28-1921

Was there an autopsy? .....

What test confirmed diagnosis? Clinical studies

(Signed) L. H. Brumbaek, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Piney Grove Cemetery — DATE OF BURIAL: Jan 1 192

20 UNDERTAKER: J. F. Ebline — ADDRESS: Reisterstown Md

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute Pelvic Inflamatory
Disease - cause of subsidy
is unknown.

D 59814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Apart. 2A. Marlbrough St. 14 WARD) 79

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon A. Gusdorff

(Residence in Baltimore: No. Apart. 2A. Marlbrough St.: 62 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH. Sept. 1, 1859
(Month) (Day) (Year)

7-AGE. 62 yrs. 3 mos. 29 dys. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work. Merchant
(b) General nature of industry, business, or establishment in which employed (or employer). (Furniture)

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Alexander Gusdorff

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Philipine Weisenau

13-BIRTHPLACE OF MOTHER (State or Country). Germa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert D. Gusdorff
(Address) Cordova Apartments

15- Filed ..... 191.....
Robert P. Harrison
Registrar.

CAUSE OF DEATH in plain terms, so that it may be understood. Omissions will delay burial permit. Please be particular and write plainly. All items important. See instructions on back of certificate.

DEC 31 1921
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or jurisdiction) thereon and from the evidence obtained by said inquest (Inquest, autopsy or jurisdiction) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Dec. 30, 1921 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Chev Shalom

DATE OF BURIAL. Jany 1st 1922

20-UNDERTAKER. Dan'l Sondheim

ADDRESS 1000 Park Royal

D 59815 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Garden Theatre on way ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Reinach

(Residence in Baltimore: No. 1741 N. Carey St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 47 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance Agt.
(b) General nature of industry, business, or establishment in which employed (or employer): 056

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Isaac Reinach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Theresa Hirsh

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Flora Reinach

(Address) 1741 N. Carey

15- Robert P. Harrison

Filed ....., 191.....

1321 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart
Acute (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cardiac Dilatation
Sudden (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)
Dec 30, 1917 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew — DATE OF BURIAL, Jany 1st, 1918

20-UNDERTAKER David Bondheim — ADDRESS 1108 W Mad Ave

N.B.—Every item of information should be given, so that it may be properly classified. Be particular in CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 59816

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank Granger

(a) RESIDENCE NO. 1319 Mt Royal Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 2 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Frank Granger.

6 DATE OF BIRTH (month, day, and year) Nov ? 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Granger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Union Memorial Hospital Records Mosher & Division Sts.

15 Filed [illegible] 19 [illegible] Registrar

C 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 29, 1921, to Dec 30, 1921, that I last saw him alive on Dec 30, 1921, and that death occurred, on the date stated above, at 11.35 P.m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/29/21

Was there an autopsy?

What test confirmed diagnosis? Operation + Clinical

(Signed) George E. W. Hardy, M. D.

19 (Address) Upton Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/3 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

CAUSE OF DEATH must be given in plain English. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83

D 59817

D 59817

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory German

(a) RESIDENCE. NO. 1010 Warick ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Jennie German

6 DATE OF BIRTH (month, day, and year) March 10, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (Retired) 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph German

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Zouder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emory German (Address) 1010 Warick St

15 Filed , 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

C 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/15, 1921, to 12/30, 1921, that I last saw him alive on 12/30, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Varicose ulcers complicated
by cardiac Insufficiency
Edema of Lungs.

(duration) 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Edema of Lungs (duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1010 Warick St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W D Dougher, M. D.

, 19 (Address) Maryland Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CAUSE OF DEATH to be stated legibly, in ink, on back of certificates. See instructions on back of certificates. TION is very important.

PLACE OF BURIAL OR CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Jan 1st 1922

20 UNDERTAKER: Family Burying Ground Assoc

ADDRESS: 5026 North

William Cook

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59818

HEALTH DEPARTMENT—CITY OF BALTIMORE

19-003

D 59818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto md

CITY OF BALTIMORE: (No. Franklin Ave Rasphurg St. 76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D'Riskey.

(a) RESIDENCE. No. Franklin Ave Rasphurg St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) April 6. 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	10	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School pupil

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer No

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Friskey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Anna R Popple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frederick Friskey (Address) Franklin Ave Rasphurg

15 Filed Dec 31 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Dec 31, 1921, that I last saw him alive on Dec 30, 1921, and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Acute Uraemia

(duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) Measles.

(duration) 1 yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? same

(Signed) Jas L Travers, M. D.

(Address) 248 So 3d St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL Jan 1 1922

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans St.

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D 59819~~ 1521 14

170 D 59819

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Johnson

(a) RESIDENCE. No. 34 W. Saratoga St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minny Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant
(Address)

15 Filed . 19 Robert P. Harrison, Registrar

C 3 1 1921 Asst. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 23rd, 1921, to Dec. 30th, 1921, that I last saw him alive on Dec 30th, 1921, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

1 Myocardial Insufficiency

(duration) — yrs. 1 mo. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Chronic Nephritis, Unknown (duration) — yrs. — mos. — ds.

Auricular fibrillation

18 Where was disease contrarted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Physical Examination

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Francis R Dieuaide, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trevillian Louisa C. Co.	Jan 1 1922

20 UNDERTAKER ADDRESS

John O. Mitchell 120 W. Fayette St.

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59820

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 091

D 59820

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Park ave St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Herford

(a) RESIDENCE. No. 1521 Park Ave. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha E. Herford

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 58 yrs. Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mfgr

(b) General nature of industry, business, or establishment in which employed (or employer): Cigar

(c) Name of employer: Balt. Mfg.

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: Julius Herford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lisette Burlaun

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Abraham Herford 2921 Nelmore Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1921, to Dec 30, 1921, that I last saw him alive on Dec 29, 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Hemiplegia) (duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis V. Hamburger, M. D.

Dec 31, 1921 (Address) 120 E Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cem. — DATE OF BURIAL: Jan 1 1922

20 UNDERTAKER: J. AHRENS & CO. FUNERAL DIRECTORS AND EMBALMERS 16R MADISON AVENUE — ADDRESS

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

Robert P. Harrison, Registrar

31 1921

Burial Permit Clerk.

D 59821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59821

CERTIFICATE OF DEATH.

(PLACE OF DEATH

CITY OF BALTIMORE (No. 3623 Ceder ave ST.: 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C Fowble

(Residence in Baltimore: No 3623 Ceder ave St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) Widowed

6-DATE OF BIRTH, Dec 27 (Month) (Day), 1852 (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), M D

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie B Heyn

(Address) 3623 Cedar Ave

15- Robert P. Harrison,

Filed....., 191.... Registrar.

Burial Permit Clerk

31 1921

N. B.—Every item of information must be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Tabular disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Hourigan M. D.

(Coroner) Dec 31 1921 (Address) 3332 Potee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westminster Md

DATE OF BURIAL, Jan 2 1922

20-UNDERTAKER Chenoweth & Son

ADDRESS Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59822

CERTIFICATE OF DEATH.

64 D 59822

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 821 W 34 (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Warner

(a) RESIDENCE. NO. 821 W 34 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha J Warner

6 DATE OF BIRTH (month, day, and year) Dec 10 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Luther E Trester

(Address) ~~821 W 34 St~~

15 Filed Robert F. Harrison, Registrar

DEC 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1921, to Dec 30, 1921,

that I last saw him alive on Dec 27, 1921,

and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Leo W Wolff M. D.

12/31/1921 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Thurmont Md	Jan 1 1922

20 UNDERTAKER ADDRESS

Ehenowerth & Son Chestnut Ave

CAUSE OF DEATH to plainly filled out. See instructions on back of certificates. TION is very important.

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1600 Bks.

59823 D 59823

HEALTH DEPARTMENT—CITY OF BALTIMORE

59823 ✓ X 109 D 59823

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital. REGISTERED NO.....

CITY OF BALTIMORE: (No. Lombard + Green STS 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Scrivener

(a) RESIDENCE. NO..... Delle Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry C Scrivener.

6 DATE OF BIRTH (month, day, and year) 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delle Md.

PARENTS

10 NAME OF FATHER Wm. Lafferty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER G. Hait

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr Henry C. Scrivener (Address) Delle Md.

15 JAN 1 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1921, to Dec 31, 1921, that I last saw h.e.w. alive on Dec 31, 1921, and that death occurred, on the date stated above, at 2:15 P.m.

The CAUSE OF DEATH* was as follows:

Intestional Obstruction

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 12-31-21

Was there an autopsy? Yes. (Partial)

What test confirmed diagnosis? Operation

(Signed) 9 W Jones, M. D.

12/31. 1921 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delle Cem Co.	Jan 3 1922
20 UNDERTAKER	ADDRESS
Easton Son	Ellicott City

CAUSE OF DEATH in plain terms. ... on back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59824

CERTIFICATE OF DEATH.

50 D 59824

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3432 Roland Av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Adams

(a) RESIDENCE. No. 3432 Roland Av ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 30 '21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	1 Day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Flora Hudnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Flora Hudnick
(Address) 3432 Roland Av

15 Filed JAN 1 - 1922 19.. ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1921, to Dec 31, 1921, that I last saw h... alive on Dec 31, 1921, and that death occurred, on the date stated above, at 4-30 P.M.

The CAUSE OF DEATH* was as follows:

Debility

Premature birth not stated

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Fair, M. D.

19.. (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shrewsberry Pa	Jan 1 1922
20 UNDERTAKER	ADDRESS
Shenowith & Son	Chestnut Ave

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59825

CERTIFICATE OF DEATH.

D 59825

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Argyle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Brandt

(Residence in Baltimore: No. 1315 Argyle Ave St.; 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	C Colored	Widower

6-DATE OF BIRTH, — (Month) — (Day) 1849 (Year)

7-AGE,	If LESS than 1 day,
72 yrs. — mos. — ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hod-Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): 135

9-BIRTHPLACE, (State or Country), Howard Co. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Brandt

(Address) 1315 Argyle Ave

15-

Filed ....., 1922., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

JAN 1 1922

CAUSE OF DEATH must be stated in every case. Information required is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 29th 1921, to Dec 30th 1921, that I saw h-m alive on Dec 29th 1921, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs (Duration) — yrs. — mos. 27 ds.

CONTRIBUTORY (Secondary) Pleurisy and Phthisis

Consumption (Duration) — yrs. — mos. 27 ds.

(Signed) Edward E. Blackman M. D.

Dec 30 1921, (Address) 1324 N Stricker St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holsonal Cem	Jan 3 1922

20-UNDERTAKER, David Handley ADDRESS 578 N Eden St

Not tuberculous. Not luetic. Not chronic nephritis simply congestion of kidneys. Old Age - more than anything else

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59826

CERTIFICATE OF DEATH.

92-079 D 59826

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1191 N Carlton ST.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Davis

(Residence in Baltimore: No. 1191 N Carlton St.; 45 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 6 (Month) (Day) 1861 (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 500

9-BIRTHPLACE, (State or Country). Caroline Co. Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maraliza Davis

(Address) 1109 Shields Place

15- JAN 1 - 1922 Filed....., 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CAUSE OF DEATH must be plainly and fully stated. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 16 1921, to December 31 1921, that I saw him alive on December 29 1921, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) William E Burke M. D.

Dec 31, 1921. (Address) 1620 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem | DATE OF BURIAL, Jan. 3 1922

20-UNDERTAKER Daniel Wemsley | ADDRESS Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Trigg) ✓

D 59827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59827

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 751 George ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline R Trigg

(a) RESIDENCE NO. 751 George ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook 671
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER John Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Trigg (Address) 751 George St

15 Filed JAN 1 - 1922 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1921, to Dec 30, 1921, that I last saw h[er] alive on Dec 30, 1921, and that death occurred, on the date stated above, at 1209 m.

The CAUSE OF DEATH* was as follows:

acute Dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

Independent (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John R Gadsby M. D.

, 19 (Address) 753 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Jan 1st 1922

20 UNDERTAKER Samuel H Handley ADDRESS 578 Biddle

CAUSE OF DEATH in plain terms. Indefinite answers such as "Heart Failure," "Old Age," "Pneumonia," "Cancer," "Consumption," "Paralysis," "Convulsions," "Dropsy," "Uremia," "Septicemia," "Blood Poisoning," "Tumor," "Abscess," "Childbirth," "Accident," "Fracture," "Drowning," "Burns," "Hemorrhage," "Suicide," "Homicide," "Found Dead," "Sudden Death," "Coroner's Case," "Unknown," "Still-born," "Premature Birth," "Marasmus," "Debility," "Senility," "Infirmities of Old Age," "Malformation," "Stillborn," "Premature," "Congenital," "Hereditary," "Contagious," "Infectious," "Epidemic," "Endemic," "Sporadic," "Acute," "Chronic," "Subacute," "Inflammation," "Fever," "Gangrene," "Ulcer," "Tuberculosis," "Meningitis," "Pneumonia," "Bronchitis," "Asthma," "Emphysema," "Pleurisy," "Peritonitis," "Appendicitis," "Hernia," "Intussusception," "Volvulus," "Obstruction," "Perforation," "Rupture," "Aneurysm," "Thrombosis," "Embolism," "Hemorrhage," "Shock," "Collapse," "Coma," "Delirium," "Convulsions," "Epilepsy," "Paralysis," "Neuritis," "Neuralgia," "Hysteria," "Insanity," "Psychosis," "Dementia," "Mania," "Melancholia," "Suicide," "Homicide," "Accident," "Fracture," "Drowning," "Burns," "Hemorrhage

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59828

CERTIFICATE OF DEATH.

91 D 59828

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1035 N. Gilmor ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Kaizer Myers

(Residence in Baltimore: No. 1035 N. Gilmor St.; 4 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) ..... (Day), 1917 (Year)

7-AGE, 4 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James W. Myer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Marie Hamlet

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James W. Myer

(Address) 1035 N. Gilmor St.

15- Filed JAN 1 - 1922, 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Given

CAUSE OF DEATH must be plainly stated. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 31. (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 29 1921, to Dec. 31 1921, that I saw him alive on Dec 31. 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

3

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(Duration) yrs. mos. 12hrs ds.

(Signed) Albert D. Driscoll M. D.

Dec. 31, 1921, (Address) 1211 W. Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1035 N Gilmor St

19-PLACE OF BURIAL OR REMOVAL, Balto. Hebrew

DATE OF BURIAL, Jan 1, 1922

20-UNDERTAKER Sol Levinson Bro

ADDRESS 1127 E Balto. St

No infection prior.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D 59829 ✓

Sta. 3 6-21 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59829

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3013 Erdman ave. ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ewalt

(a) RESIDENCE. No. 3013 Erdman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Ewalt

6 DATE OF BIRTH (month, day, and year) Jan. 2-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md.

PARENTS

10 NAME OF FATHER Philip Ewalt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Simple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Grace L. Barton 3013 Erdman ave.

15 Filed JAN 1 - 1922 16 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1920, to Dec 31, 1921, that I last saw h[illegible] alive on Dec 30, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Paralysis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wallis W White Jr. M. D.

1/31/22 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Jan. 2 1922

20 UNDERTAKER Wm C. Black ADDRESS 927 N. Bdwy.

N. B.—WRITE PLAINLY. WITH INK. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59830

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hospital (ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Maygers

(a) RESIDENCE. No. 815 S. Bouldin St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13th 1920.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1 yr.	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Maygers

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Mathias

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Conrad Maygers.
(Address) 815 S. Bouldin St

15 Filed JAN 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/20/21, 19 , to 12/29/21, 19 ,
that I last saw h alive on 12/28/21, 19 ,
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

OVER

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 1 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Pearson, M. D.

12/29/21 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Jan. 2nd 1922
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH to be plainly stated. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Empyema followed an attack of acute Bronchopneumonia.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 59831

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3301 Eastern Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina K. De Boy.

(a) RESIDENCE. NO. 3301 Eastern Ave., ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. De Boy.

6 DATE OF BIRTH (month, day, and year) April 23-1842.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John J. Tieffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Christina Hoffstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Mrs. Hugh McCall. 3301 Eastern Ave.

15 Filed JAN 1 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1921, to Dec 30, 1921, that I last saw her alive on Dec 29, 1921, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Reifschneider, M. D.

, 19 (Address) 2939 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Jan. 2 1922

20 UNDERTAKER Lilly and Zuler

ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms. [illegible] on back of certificates. TION is very important. See instructions on back of certi

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 59832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 083

91-D 59832

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE Municipal Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Parks

(a) RESIDENCE. NO. 1029 Argyle Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed JAN 2 1922, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from October 26, 1921, to December 28, 1921, that I last saw him alive on December 28, 1921, and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Varicose Ulcer Leg - Right

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho - Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings.

(Signed) [illegible], M. D.

(Address) Municipal Hospital. 12/29/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 2 1922
20 UNDERTAKER David Carson	ADDRESS 916 Pa ave

CAUSE OF DEATH to be plainly written, in ink, in duplicate. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59833

CERTIFICATE OF DEATH.

REGISTERED NO. 31

D 59833

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST.: No (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Harry Buckheimer

(a) RESIDENCE. NO. 3402 Leverton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 657

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Co Md

PARENTS

10 NAME OF FATHER Buckheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet E. Donker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Charles Buckheimer (Address) 3402 Leverton

15 Filed . 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

JAN 1 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/28/ . 1921 . to Dec 31 . 1921 . that I last saw him alive on Dec 31 . 1921 . and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 wks

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History. Physical Exa

(Signed) Stanley Grabill, M. D.

19 (Address) 2849 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Jan 3 1922
20 UNDERTAKER David Easton	ADDRESS 916 Ca ve

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Gant

D 59834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 50

D 59834

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 581 Walnut Alley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Gant

(Residence in Baltimore: No. 581 Walnut Alley St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	colored	Single

6-DATE OF BIRTH. Dec. 28, 1921
(Month) (Day) (Year)

7-AGE. yrs. mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Geo Gant

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Susie Capers

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Gant

(Address) 581 Walnut Alley

15-

Filed ....., 191.....

Registrar.

JAN 1 - 1922

Burial Permit

N. B. Every item of information must be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 30, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patient treated Acute,

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) No history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec 31, 1921 (Address) 2802 Emmenadale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	Jan 2, 1922
20-UNDERTAKER. David Easton	ADDRESS 716 Gay

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59835

CERTIFICATE OF DEATH.

173

D 59835

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Max Cohen

(a) RESIDENCE. NO. 2543 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married-

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Sarah Katun Cohen

6 DATE OF BIRTH (month, day, and year): Feb 26, 671

7 AGE — Years: 50 — Months: 10 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Manufacturer 086
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing-
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia-

PARENTS

10 NAME OF FATHER: Jacob Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael Boyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia-

14 Informant (Address): Hosp Records-

15 Filed JAN 1 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from December 20, 1921, to January 1, 1922, that I last saw him alive on January 1, 1922, and that death occurred, on the date stated above, at 7 56 m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis with obstructive jaundice.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Internal hemorrhage - Exhaustion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 22, 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) George E. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL: Jan 1 1922

20 UNDERTAKER: Jack Lewis — ADDRESS: 411 E Balto

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See back of certificates.
TION is very important. See instructions on back

S— 6-9-19—H. P. Co.—1000 Blks.

D 59836

HEALTH DEPARTMENT—CITY OF BALTIMORE

59836 D 59836 CERTIFICATE OF DEATH. X 60-607 59836

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bettie Chalk

(a) RESIDENCE. No. Alberton, Md ST.. WARD. Alberton Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

3a If married, widowed, or divorced
(or) ~~WIFE of~~ wife of Chas E Chalk

6 DATE OF BIRTH (month, day, and year) May 21, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Stanton
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.
12 MAIDEN NAME OF MOTHER Annie Boswell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Husband.
(Address)

15 Filed . 19 Registrar

JAN 2 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 1 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-14, 1921, to 1-1, 1922, that I last saw h— alive on 1-1, 1921, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Hypo-tatricosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular fib-rillation (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Gdns.	Jan 4 1921
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had benign toxic thyroid.
Became toxic during
menopause. No evidence
of exophthalmic goitre

D 59837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5211 York Road, Govans ST.; 27 WARD) 45

2-FULL NAME Lawrence B. McCabe

(a) RESIDENCE. NO. 5211 York Road, Govans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ellen Keaveny

6 DATE OF BIRTH (month, day, and year): Mar. 11, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: R. R. Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Havre de Grace Maryland

PARENTS

10 NAME OF FATHER: Lawrence B. McCabe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rosalie McFeely

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Eileen McCabe

(Address): 5211 York Road, Govans

15 Filed ..... 19 ..... Registrar

JAN 2 - 1922 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31 19 21

17 I HEREBY CERTIFY, That I attended deceased from October ....., 19 21, to December 31, 19 21, that I last saw h[illegible] alive on December 31, 19 21, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Lymphosarcoma (Hodgkin's)

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. K. A. Mayer, M. D.

12.31, 19 21 (Address) 2438 Linkwood Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Govans	1/2 '22
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvet

mation should be given in plain terms, so that the CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59838

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Linden Avenue ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Stirling

(a) RESIDENCE. NO. 1511 Linden Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Cotten

6 DATE OF BIRTH (month, day, and year) June 20, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Stirling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Stirling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs. Louise Stirling 1511 Linden Avenue

15 Filed Robert P. Harrison, Registrar

2-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1915. to Decemb 30. 1921.

that I last saw him alive on December 30. 1921.

and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Terminating in (duration) 6 yrs. 4 mos. ds. Coma. Illness from

CONTRIBUTORY (Secondary) Cataract (duration) above 3 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fehling + Benedicts test

(Signed) A C Pole, M. D.

. 19 (Address) 203 N Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	1/2 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

CAUSE OF DEATH must be properly certified. See instructions on back of certificates. TION is very important.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59839

CERTIFICATE OF DEATH.

129

D 59839

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 137 E Eutaw ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Teresa Buchheit

(a) RESIDENCE NO. 137 E Eutaw ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Buchheit

6 DATE OF BIRTH (month, day, and year) Oct 7 1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Ribon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant David Earlon
(Address) 916 E Eutaw

15 Filed JAN 3 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1921, to Jan 1, 1922, that I last saw her alive on Dec 31, 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What (est confirmed diagnosis? Phys.

(Signed) Wm McClafferty M. D.

1/1/1922 (Address) 139 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bakd Cem	Jan 3 1922
20 UNDERTAKER	ADDRESS
David Earlon	916 E Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59840

CERTIFICATE OF DEATH.

58

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Vine St.: 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Stanley

(a) RESIDENCE. NO. 509 Green Willow ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labourer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt. Co. Md.

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: David Easton (Address): 916 Lemmon

15 (Date) . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1921

17 I HEREBY CERTIFY, That I attended deceased from 2:25 P.M. Dec. 31, 1921, to 9:57 P.M. Dec 31, 1921, that I last saw him alive on Dec 31. 8, 1921, and that death occurred, on the date stated above, at 9:57 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis L Dalaglisse, M. D.

Jan 1, 1922 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 4 1922

20 UNDERTAKER: David Easton

ADDRESS: 916 Lemmon

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

N 9 - 1922

Spec.—8-24-14—M. & T.—2000 Blks.

D 59841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59841

CERTIFICATE OF DEATH.

REGISTERED NO. C 83

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Market St.) (Mt Vernon WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Laurusitis

(Residence in Baltimore: No. 2215 Market St.) (If not in Baltimore, write the name of State.) 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) M

6-DATE OF BIRTH, June (Month) 30 (Day), 1871 (Year)

7-AGE, 50 yrs. 6 mon. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Lithuania

PARENTS.

10-NAME OF FATHER. George Maczulonis

11-BIRTHPLACE OF FATHER (State or Country). Lithuania

12-MAIDEN NAME OF MOTHER. Mary Antanavis

13-BIRTHPLACE OF MOTHER (State or Country). Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Laurusitis

(Address) 638 Baltimore

15- Robert B. Harrison,

Filed....., 191..... Registrar.

By ....., 192.. Special Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14 1921, to Dec. 31 1921, that I saw h e alive on Dec. 31 1921, and that death occurred, on the date stated above, at 12:25 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
+ Pulmonary Embolism
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Varicose Thrombophlebitis
(Duration) yrs. mos. 18 ds.

(Signed) John B. Gilcrease M. D.

1-4, 1922 (Address) 638 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2215 Market St Mt Vernon

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Janv. 3th, 1922

20-UNDERTAKER John Grebliauckas

ADDRESS 425 S Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59842

D 59842

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 62 Russell St. WARD 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Behrman

(a) RESIDENCE. No. 62 Russell St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L. A. Behrman

6 DATE OF BIRTH (month, day, and year) Mar. 1 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown 1/1/22

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs. Myers
(Address) 62 Russell St.

15 Filed 19 Robert P. Harrison, Registrar
12-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1921

17 I HEREBY CERTIFY, That I attended deceased from 12-20, 1921, to 12-31-, 1921, that I last saw her alive on 12-30, 1921, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Insufficiency

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 61 Russell St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical only

(Signed) Philip S. Towles, M. D.

(Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hills	Jan 2 1922

20 UNDERTAKER Wm. Miller & Son Fisk ADDRESS 1835 W. Fayette

CAUSE OF DEATH in plain words. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 913 Ryan St - (St.) 21 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget - Burns

(a) RESIDENCE. (Usual place of abode) No. 913 Ryan St - St., Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Burns.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Wm Burns. (Address) 913 Ryan St -

15 Filed ....., 19.... Robert J. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1921, to Dec 30, 1921, that I last saw her alive on Dec 30, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Old age and General Debility

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph E. Muse, M. D.

Jan 1. 1922 (Address) 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 2nd 1922
20 UNDERTAKER John J Cowan & Son. Per J.J. Cowan	ADDRESS 90 Hollins St.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59844

CERTIFICATE OF DEATH.

180-601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 S Mowroe ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Howard Fouch

(a) RESIDENCE. No. 521 S Mowroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Fouch

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary Dunkley

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mr Henry Fouch
(Address) 521 S Mowroe St

15 Filed Jan 2, 19 22 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1921, to Jan 1, 1922, that I last saw h~~im~~er alive on Dec 31, 1921, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows: OVER

Broncopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary Orditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Norbert C Schuh, M. D.

Jan 1 1922 (Address) 2151 Druid Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery.	Jan 24 1922
20 UNDERTAKER	ADDRESS
John F Cowan & Son Per F F Cowan	90 Hollins St

Jan 2 1922

TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59845

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5306 Wenner Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joel M. Cooke

(a) RESIDENCE. NO. 5306 Wenner Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Fischer Cooke.

6 DATE OF BIRTH (month, day, and year) July 11 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet metal worker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer Bartlett & Hayward Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Eugene F Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Hannah J Brewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Clara Cook.
(Address) 5306 Wenner Ave.

15 Filed Robert P. Harrison, Registrar
N 2 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Dec 30, 1921, that I last saw him alive on Dec 30, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Health Dept.

(Signed) Leonard E Beach, M. D.

, 19 (Address) 2231 St Paul St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 3rd, 1922
20 UNDERTAKER John J Cowan & Son Jos F Cowan	ADDRESS 908 Fallsway

CAUSE OF DEATH in plain terms. So that a stranger can understand. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59846

CERTIFICATE OF DEATH.

X 53 D 59846

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

2-FULL NAME Samuel Fuqua

(a) RESIDENCE. NO. Colfax N. Car. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 500

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Samuel G. Fuqua

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Mittie Molloy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant (Address)

15 Filed 1-4 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1921, to Dec 31st, 1921, that I last saw him alive on Dec 31st, 1921, and that death occurred, on the date stated above, at 2.02 P. m.

The CAUSE OF DEATH* was as follows:

Myeloid leucemia

(duration) 11 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination.

(Signed) Francis R. Dieuaide, M. D.

Dec. 31, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Colfax N.C.	1.2.22 19
20 UNDERTAKER	ADDRESS
H.E.Dugas	424 N.Broadway

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59847

64 D 59847

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 E 23rd St, ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Brown

(a) RESIDENCE No. 439 E 23rd St, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Chas Brown

6 DATE OF BIRTH (month, day, and year): Mar 30-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9		

8 OCCUPATION OF DECEASED

037

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): V a

PARENTS

10 NAME OF FATHER: Harrison Logan

11 BIRTHPLACE OF FATHER (city or town) (State or country): V a

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Chas Brown

(Address) 4392 E 23 St 20

15 Filed Robert P. Harrison, Registrar

JAN 24 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1921, to Dec 30th, 1921, that I last saw her alive on Dec 30th, 1921, and that death occurred, on the date stated above, at 5 00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute pulmonary Congestion (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? d

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Gid Hall, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan 2 1922
20 UNDERTAKER	ADDRESS
George A. Holland	1631 Druid Hill Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

D 59848 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59848

64

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 160 W. Cross St. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William A. Ruhland.

(Residence in Baltimore: No. 160 W. Cross St.) 69 St.; 1 yrs.; mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, November 5th. 1852, 1
(Month) (Day) (Year)

7-AGE, 69 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Varnisher.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William K. Ruhland.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth Kontner.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George G. Ruhland. (son)

(Address) 160 W Cross St.

15- 2- 1922, 191.... Registrar.

Robert F. Harrison
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31st. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) Otto F. Leonhardt M. D.
(Coroner)

Jany. 2nd, 1922 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Jan. 3rd. 1922

20-UNDERTAKER E. Sellman and Son ADDRESS 1034 Hanover St.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 59849

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59849

1 PLACE OF DEATH

REGISTERED No. C 179

CITY OF BALTIMORE: (No. 2827 Rayner Av. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche E. Selby

(Residence in Baltimore: No. 2827 Rayner Av. St.; 76 yrs. 1 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Nov. (Month) 30 (Day), 1845 (Year)

7-AGE: 76 yrs. 1 mos. 12 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Alexander J. White

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Elgie J. White

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence S. Barrett

(Address) 2827 Rayner Ave

15- Robert P. Harrison,

Filed ....., 191 ..... Burial Permit Clerk. REGISTRAR

2-1922

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan. (Month) 1 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1921, to, Dec 31 1921, that I saw h.. alive on Dec 31 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs ..... mos. ..... ds.

Contributory (SECONDARY) Uraemia

(Duration) yrs ..... mos. ..... ds.

(Signed) Frank N. Gilles M. D.

Jan 2nd 1922 [Address] 2838 Edmondson Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral DATE OF BURIAL: Jan 3, 1922

20-UNDERTAKER: George J. Smith ADDRESS: 2202 Fayette St

state CAUSE OF DEATH in plain terms, TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59850

CERTIFICATE OF DEATH.

57

D 59850

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No Ashburton Liberty Road ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalia May Gittings

(a) RESIDENCE. No. Ashburton Liberty Road WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S Gittings

6 DATE OF BIRTH (month, day, and year): June 16th 1848

7 AGE: Years 74 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Henry May

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: A Lee Corrissey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Cecil Barrett

(Address): N.J.

15 Filed ..., 19... Registrar

N 2 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1921, to Jan 1, 1922, that I last saw h[illegible] alive on Jan 1, 1922, and that death occurred, on the date stated above, at 6-30 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. D Atkinson, M. D.

, 19 (Address) 1010 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	January 3 1922
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Co	Ednard & Collon

CAUSE OF DEATH to [illegible] TION is very important. See instructions on back of certificates.

Spec. 6-9-19—B. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59851

CERTIFICATE OF DEATH.

1 9 D 59851

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N. Washington ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Rexroth

(a) RESIDENCE. NO. 130 N. Washington ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) WIFE of Mary Rexroth

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Varnisher

(b) General nature of industry, business, or establishment in which employed (or employer) Varnisher

(c) Name of employer Reliable Furn. Co

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Ferdinand Rexroth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wenske

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ferd. Rexroth
(Address) 130 N. Washington St

15 Filed 1922 Robert P. Harrison
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 19 21, to Dec 30, 19 21,

that I last saw him alive on Dec 30, 19 22

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Meyer Jr. M. D.

1/21 19 22 (Address) 1638 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 2d 1922
20 UNDERTAKER	ADDRESS
Geo Leinbach & Son	647 W. Balto.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

JAN 2 1922

Spec.—1-10-21—M&T—1500 Bks.

D 59852

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59852

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1117 S. Decken Avenue, WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia E. Murphy

(a) RESIDENCE NO. 1117 S. Decken Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced ~~WIFE of~~ (or) WIFE of Albert Murphy

6 DATE OF BIRTH (month, day, and year)				
7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) none 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander Cramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ellen Humphrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Albert Murphy (Address) 1117 Decken Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

12-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 1st, 1922, that I last saw her alive on Dec 31, 1921, and that death occurred, on the date stated above, at 2-05 P. m.

The CAUSE OF DEATH* was as follows:

exhaustion

vomiting.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) abdominal tumor (Ovaria Cyst?) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. F. V. Wright, M. D.

1, 1922 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 3 1922

20 UNDERTAKER Henry Woods & Son — ADDRESS 1301 E Eager St

CAUSE OF DEATH In plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably
Cancer of Pelvis —
First organ involved unknown.
Clinical

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59853

CERTIFICATE OF DEATH.

91

D 59853

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 N. Chapel ST., 8 WARD)

2-FULL NAME Anna M. Kreinhoefner

(a) RESIDENCE No. 1605 N Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Kreinhoefner

6 DATE OF BIRTH (month, day, and year) Oct 4 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	62	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anton F. Bohm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Haschberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Jos. Kreinhoefner

(Address) 1605 N. Chapel St

15 Filed , 19 Registrar

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28. , 1921 , to Dec. 31. , 1921 .

that I last saw her alive on Dec. 31. , 1921 .

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos 1 dy.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) H. J. Hahn, M. D.

Dec. 31 1921. (Address) 1001 Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 3 1922
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59854 161 001 D 59854

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 Eastern Ave ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter W. Hansen

(Residence in Baltimore: No. 1928 Eastern Ave St.: yrs., mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 20 (Day), 1921 (Year)

7-AGE, yrs. mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER. Charles W. Hansen

11-BIRTHPLACE OF FATHER (State or Country). Brooklyn N.Y.

12-MAIDEN NAME OF MOTHER Helen W. Cwalina

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen W. Hansen

(Address) 1928 Eastern Ave

15- Filed JAN 2 1922, 191 Robert P. Harrison, Registrar.
Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1921, to Jan 1 1922, that I saw him alive on Dec 30 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mabel Belt M. D.

Jan 1, 1922 (Address) 1320 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, Jan. 2, 1922

20-UNDERTAKER Wendell J. Heppe ADDRESS 37 E Lan St

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59855

CERTIFICATE OF DEATH.

90 D 59855

1-PLACE OF DEATH Hebrew Aged Home

CITY OF BALTIMORE: (No. 105 Aisquith St., ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Levin

(a) RESIDENCE NO. 105 Aisquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ ~~White~~

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1835

7 AGE: Years 86; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1411 E Baltimore St

15 Filed JAN 2-1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1921, to Jan 1, 1922, that I last saw h[im] alive on Jan 1, 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Influenza

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Brayton, M. D.

1/2, 1922 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mut Cemet — DATE OF BURIAL Jan 2 1922

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Abbreviations must not be used. Diseases of women and children must be specified. Violent deaths must be fully explained. Physicians are required to report to the Health Department the existence of every case of infectious disease coming under their observation. Failure to do so is a misdemeanor. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 8 WARD)

REGISTERED No. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. David Bernhart

(a) RESIDENCE No. 1303 N. Port St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct-4 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairyman. 145

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Father Mr. Augusta
(Address) 1301 N. Port St

15 Filed 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-3 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/29 1921 to 1/2 1921,
that I last saw him alive on 1/2 1921,
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

1. Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Senility and Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S. Zinberg, M. D.

1/2, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 1/3 1922

20 UNDERTAKER William Cook for J. J. Murphy — ADDRESS 6022 North

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. IMPORTANT. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59857 ✓ D 59857

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 N Chapel St. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George T Boller

(a) RESIDENCE NO. 1523 N Chapel ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Boller

6 DATE OF BIRTH (month, day, and year) May 28/1880

7 AGE Years 41 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Produce

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Louis V Boller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary L Burningham

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mary E Boller
(Address) 1523 N Chapel St

15 Filed ..... Robert P. Harrison, Registrar

Carman 1701 N Caroline Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

I HEREBY CERTIFY, That I attended deceased from Dec 13, 1921, to Jan 1, 1922, that I last saw him alive on Jan 1 1922, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic asthma, Bronchitis

Cardiac Insufficiency

OVER

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C B Carman, M. D.

1-2, 1922 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Jan 4 1922

20 UNDERTAKER William Beck — ADDRESS 502 E Nath Av

Per J. J. Murphy

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous. Not cancerous. No further history

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59858

CERTIFICATE OF DEATH.

17 D 59858

REGISTERED No. C

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Franklin Square Hospital St. 18 Ward)

2-FULL NAME Thomas P. McGlinn

(Residence in Baltimore: No. 227 North Carrollton Ave St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, about 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER James McGlinn

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Hayes

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Parker

(Address) 901 Hukeland Ave

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 30, 1911 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

Accident (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) G. E. Blades M. D. (Coroner)

Dec 31 1911 (Address) 543 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, 1/3, 1912

20-UNDERTAKER William Cook for T. J. Murphy

ADDRESS 502 E Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every certificate is important. See instructions on back of certificate.

JAN 2 1922 Burial Permit Work

Spec.—8-24-14—M. & T.—2000 Bks.

D 59859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 822 N. Carrollton ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Annie Badger

(Residence in Baltimore: No. 822 N. Carrollton ave St.: life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, about 66 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 039

9-BIRTHPLACE, (State or Country), Unknown Md

PARENTS.

10-NAME OF FATHER, David Henry

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jane Henry

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Henry

(Address) 822 N Carrollton Ave

15- Robert F. Harrison,

Filed ....., 191..... Registrar.

2-4-1922 Burial Permit Clerk.

CAUSE OF DEATH. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1921, to Jan 1 1922, that I saw h[er] alive on Dec 31 1921, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Probably Carcinoma of Liver 2 Weeks

Probably senile marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza 2 Weeks Bronchitis Two or three weeks

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carlton McCook M. D.

Jan 1, 1922 (Address) 1107 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Pikesville Md

DATE OF BURIAL, 1-3, 1922

20-UNDERTAKER Wells and Cook 6 Pet Supply

ADDRESS 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59860

CERTIFICATE OF DEATH.

1920 59860

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO 2824 Fredenda ST. (or WARD) 20

2-FULL NAME Frederick M. Witt

(a) RESIDENCE. NO. 2824 Fredenda ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Witt

6 DATE OF BIRTH (month, day, and year) Feb 14 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	10	16	

8 OCCUPATION OF DECEASED 013

(a) Trade, profession or particular kind of work Beef Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Beef Pork Packing

(c) Name of employer Am Solenderery Con

9 BIRTHPLACE (city or town) (State or country) Lynchburg Va

PARENTS

10 NAME OF FATHER Joel Witt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lynchburg Va

12 MAIDEN NAME OF MOTHER Annie E Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Clarence H. Witt
(Address) 2824 Fredrick Ave

15 Filed JAN 2 - 1922 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1921, to Dec 31, 1921, that I last saw h. alive on Dec. 30, 1921, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Asa L Wilson, M. D.

1231 1922 (Address) 2565 Fredenda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Jan 2 1922
20 UNDERTAKER George L Schwab	ADDRESS 201 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be used for statistical purposes. Every certificate should be filled out in full. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 59861 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 59861

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 22 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank F. Tibbetts

(a) RESIDENCE. No. Sharp & Montgomery St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10 NAME OF FATHER Wm. Tibbetts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER Lorinda Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Vermont

14 Informant: Hospital Records

(Address) ~~M. T. H.~~

12-30-1921 Robert F. Harrison

Municipal Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1921, to Dec. 30, 1921, that I last saw him alive on Dec. 29, 1921, and that death occurred, on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Paralysis Agitans

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L. Palaglucca M. D.

12-30-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 2 1922
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

CAUSE OF DEATH must be given. See instructions on back of certificates. ATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59862

CERTIFICATE OF DEATH.

1920 59862

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 618 Burgundy ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm F. Sye

(Residence in Baltimore: No. 618 Burgundy St. St.; 55 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Widow

6-DATE OF BIRTH, Sept ....., 1866
(Month) (Day) (Year)

7-AGE, 55 yrs. 3 mos. ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Pub

9-BIRTHPLACE, (State or Country), U. S.

PARENTS.

10-NAME OF FATHER, Charles Sye

11-BIRTHPLACE OF FATHER (State or Country), U. S.

12-MAIDEN NAME OF MOTHER Sykes

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Sye

(Address) 618 Burgundy St

15-

Filed ....., 191.... Robert F. Harrison,
Registrar.

JAN 2 - 1922 Special Permit Clerk.

CAUSE OF DEATH must be plainly stated. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31st, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5th 1921, to Dec 31st 1921, that I saw h in alive on Dec 29th 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis (Uremic)

(Duration) ....yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jas O Carson M. D.

12-31, 1921. (Address) 1063 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	1-3, 1922
20-UNDERTAKER Jos Hoffheimer	ADDRESS 1067 W Balto

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14990 D 59863 — X 145 D 59863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST.: ? WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Holice Davis

(a) RESIDENCE. No. Weston West Va ST., WARD. Weston W. Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 12th 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Samuel C. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Della Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant
(Address)

15 Filed , 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30th, 1921, to Dec 30th, 1921, that I last saw h living alive on Dec 30th, 1921, and that death occurred, on the date stated above, at 1:30 p m.

The CAUSE OF DEATH* was as follows:

Bullous Impetigo

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No. Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Weston West Va	Jan 2 1922

20 UNDERTAKER Joseph Adkins ADDRESS 226 N Bway

CAUSE OF DEATH must be given in plain English—DIAGNOSIS is very important. See instructions on back of certificates.

JOHNS HOPKINS HOSPITAL

ROBT. P. MATTISON,

Burial Permit Clerk.

JAN 2 1922

D 59864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59864

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Levi

(Residence in Baltimore: No. 841 W Lexington St. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1 (Year)

7-AGE. about 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. S. Hecht

(Address) Eutaw Place

15- Robert P. Harrison,
Jan 2 1922 Filed ....., 191.....
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 1 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ topsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on body

(Duration) a few hours

CONTRIBUTORY (Secondary) Accidentally caught fire from Infected match, a few hours

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Greenglass M. D. (Coroner.)

1-1-, 1922 (Address) 113 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew

DATE OF BURIAL, Jan 2, 19 22

20-UNDERTAKER J. Ahrens Co

ADDRESS 1611 Madison

Every item of information must be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59865

CERTIFICATE OF DEATH.

10

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Willay Ave ST. Gardnville 110 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Bender

(a) RESIDENCE. NO. 15 Willay av ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21-17

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Richard Bender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Alice England

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweeden

14 Informant (Address) Richard Bender 15 Willay av

15 Filed , 19 Robert P. Harrison, Registrar

2- 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Jan 1st 1922

that I last saw h alive on Jan 1st 1922

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diphtheria

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physicians Signs

(Signed) U. E. Homer, M. D.

Jan 2, 1922 (Address) 1301 N Bat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Jan 2 1922

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. See back of certificates. TION is very important. See instructions on back

D 59866 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 134 D 59866

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 538 E. Fort Ave. St. 24 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret W. Mulcany.

(Residence in Baltimore: No. 538 E. Fort Ave. St.; 29 yrs., 3 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married

6-DATE OF BIRTH, September 26th. 1892., 1 (Month) (Day) (Year)

7-AGE, 29 yrs. 3 mos. 4 ds. IF LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Christian Aubel.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Katherine Hoff.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel D. Mulcany. (husband)

(Address) 538 E. Fort Ave.

15-

Filed....., 191... Registrar.

JAN 2 - 1922 Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 30th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to h2r death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis due to Abortion, non criminal.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) (.....)

(Duration)..... yrs..... mos..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Jany. 2nd, 1922. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Jan. 4, 1922

20-UNDERTAKER F. A. Krause & Son ADDRESS 703 Hanover

R.—Every item of information must be properly classified. Every blank must be filled. Where there is no information, write "Unknown." Where the question is not applicable, write "None." Be sure that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59867

D 59867

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3327 Foster Ave. ST.: 76 WARD)

2-FULL NAME Maria Reinsfelder.

(a) RESIDENCE. NO. 3327 Foster Ave ST., 76 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 27-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Reinsfelder.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto city Md.

12 MAIDEN NAME OF MOTHER Katie Schlee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City.

14 Informant (Address) John Reinsfelder 3327 Foster Ave.

15 Filed. . 19 Registrar

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1921, to Jan 1, 1922, that I last saw her alive on Jan 1, 1922, and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis acute (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Fellow M. D.

1/2, 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Jan. 4 1922

20 UNDERTAKER	ADDRESS
Lilly and Zeiler	403 S. Broadway

ROBERT P. HARRISON,
Permit Clerk

D 59868

Spec. 6-9-19—H. P. Co.—1000 Blks.

59868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59868

59868

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Sullivan

(a) RESIDENCE. NO. 2019 Homewood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Feb 16~~ July 16 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	~~10~~ 5	~~11~~ 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk City Hall

(b) General nature of industry, business, or establishment in which employed (or employer) Record Dept.

(c) Name of employer City.

9 BIRTHPLACE (city or town) ~~Baltimore~~ (State or country) N. Y. C.

PARENTS

10 NAME OF FATHER Geo P. Sullivan

11 BIRTHPLACE OF FATHER (city or town) ~~Balto~~ Albany (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Nora Healey ~~Nora Smyth~~

13 BIRTHPLACE OF MOTHER (city or town) Albany N.Y. (State or country) ~~Md~~ U.S.

14 Informant Mrs. Nora Sullivan

(Address) 2019 Homewood Ave

15 Filed JAN 3 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1921, to Dec 31, 1921, that I last saw him alive on Dec 31, 1921, and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory P. S. & S.

(Signed) Frank C. Marino, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

New Cathedral Cem. Jan 3 1922

20 UNDERTAKER ADDRESS

E A Weichfeld Jr 601 E 22 St.

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

ROBERT R. KRAUTER, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

57869 D 59869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59869 57869 172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 122 Maryland Ave. ST., Raspberry 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Alexander Kenney

(a) RESIDENCE No. 122 Maryland Ave ST. 26 WARD Roslyn, Balt.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Laura V. Kenney

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Co. Maryland

PARENTS

10 NAME OF FATHER Thomas S. Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emily

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Laura V. Kenney
(Address) Md. Ave. Roslyn

15 Filed JAN 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from 4 P. M. Dec 21, 1921 to 5 P. M. Dec 31, 1921.

that I last saw h alive on same date, 19 ..,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Fracture, Base of Skull, due to a fall (accidental) (Over)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. McAllister M. D.

1/1/1922 (Address) 13 Bel Air Road, Roslyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Chapel Cemetery	Jan 6th 1922
20 UNDERTAKER	ADDRESS
Frank Lassahn Sons	Fullerton Md

CAUSE OF DEATH in plain terms, so that it may be correctly classified. Name of disease alone is not sufficient. If from accident, violence or casualty, state how it occurred. If from any disease of a female specific to her sex, state which. If from any disease peculiar to infants, state whether it was a premature birth. If from any disease incident to any occupation followed by deceased, state the same. If from any disease of an organ, state which. If from old age, state what was the principal disease or cause of decline. If from any cause dependent upon pregnancy, state the same. If from any cause dependent upon childbirth, state the same. If from any cause dependent upon abortion, state the same. If from any cause dependent upon miscarriage, state the same. If from any cause dependent upon stillbirth, state the same. If from any cause dependent upon premature birth

59870 HEALTH DEPARTMENT—CITY OF BALTIMORE 59870

D 59870 CERTIFICATE OF DEATH. 157 D 59870

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15 Druid Hill Ave. ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George C. Leger.

(Residence in Baltimore: No. 21 S. 11th St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W	Divorced

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Dont Know 087
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Dont Know

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Capt Geo Henry

(Address) Court House

15-

Filed JAN 3 - 1922 ROBERT R. KRAUTER. Registrar.

c/o. Amer. Ex Nat Bank Co

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide by Strangulation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Easley M. D.
(Coroner.)

1-7-22, (Address) City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Winchester N. H. DATE OF BURIAL, Jan 2nd 1922

20-UNDERTAKER Wm Cook ADDRESS 502 E Hoff

Important. See instructions on back of this certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

KELLEY

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59871

D 59871

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 S. Ann ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kelley.

(a) RESIDENCE. NO. 715 S. Ann ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kelly.

6 DATE OF BIRTH (month, day, and year) Oct. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer on 040

(b) General nature of industry, business, or establishment in which employed (or employer) City Works.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Kelley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Annie Kelley (Address) 715 S. Ann St.

15 Filed JAN 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30th 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/13/21 to Dec. 30 - 1921, that I last saw him alive on Dec 27 - 1921, and that death occurred, on the date stated above, at 10 20 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Enteritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? — no clinical

What test confirmed diagnosis? —

(Signed) F. W. Brunmann, M. D.

(Address) 1919 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan 3 1922
20 UNDERTAKER	ADDRESS
Lilly & Geiler	403 N Wolfe

mation should be carefully supplied. Entries must be made in ink or indelible pencil, so that it may be properly classified. Fill in all items. CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill in all items. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59872

CERTIFICATE OF DEATH.

74 D 59872

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Mosher ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Gibson

(a) RESIDENCE. No. 1302 Mosher ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred whole life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary Gibson

6 DATE OF BIRTH (month, day, and year) Sept. 19-1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lock tender for Penn. R.R.

(b) General nature of industry, business, or establishment in which employed (or employer): Penn. R.R.

(c) Name of employer: Penn. Rail Road

9 BIRTHPLACE (city or town) (State or country): Balto. City Md.

PARENTS

10 NAME OF FATHER Henry Wm. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. City Md.

12 MAIDEN NAME OF MOTHER Catherine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. City Md.

14 Informant: Mrs. Mary Gibson
(Address) 1302 Mosher St.

15 Date received JAN 3 - 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1921, to Dec. 31, 1921, that I last saw him alive on Dec. 31, 1921, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. McCourtney, M. D.

Jan 1 1922 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 3 1922

20 UNDERTAKER Geo W. Little

ADDRESS 1700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59873 ✓ 59873

59873

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hospt. St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. A. Stevens.

(a) RESIDENCE. No. 1811 Bolton St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred always yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a ~~Married~~, widowed, ~~or divorced~~
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17, 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm. H. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Poulter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel J. A. Stevens
(Address) 1811 Bolton St.

Filed JAN 3 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1921, to Jan 1, 1922,
that I last saw him alive on Jan 1, 1922,
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis.
Internal Hemmorrhage.
Contributory Chronic Nephritis.

(duration) 4-5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes Date of Dec 1, 1921

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) Thos. Lucas Lawrence M. D.

1/2/22 1922 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Jan 3 1922
20 UNDERTAKER Geo W. Little	ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH to plainly filled in. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 59874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2705 Harlem Ave. ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie R. Ahring.

(a) RESIDENCE NO. 2705 Harlem Ave. ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ---- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Ahring.

6 DATE OF BIRTH (month, day, and year) Dec 25th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York, Pa.

PARENTS

10 NAME OF FATHER ------ Reynolds.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant William F. Ahring. (husband) (Address) 2705 Harlen Ave.

15 Filed JAN 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30th. 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to December 30 1921, that I last saw h.e.r alive on December 30th. 1921, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis. (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Otto M. Reinhardt M. D.

(Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cem. DATE OF BURIAL Jan 3 1922

20 UNDERTAKER Robert S. Lewis ADDRESS 2700 Edmondson Ave

Spec.—6-5-19—H. P. Co.—1000 Bks.

D 59875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59875

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Harlem Ave.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma S. Kleibacker

(a) RESIDENCE NO. 2809 Harlem Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 13 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard Kleibacker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clara E Kleibacker

(Address) 2809 Harlem a

15 Filed JAN 3 - 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1921, to Jan. 1, 1922.

that I last saw h— alive on Jan. 1, 1922

and that death occurred, on the date stated above, at 2.45 P.m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Hennessy, M. D.

(Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Jan 4 1922

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH to be plain terms, and must not be indefinite or misleading. Name of disease alone is insufficient. Supplementary information required is indicated on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 59876

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1523 Argyle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Howe

(a) RESIDENCE. No. 1523 Argyle Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Howe

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Howe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael Howe
(Address) 1523 Argyle Ave

15 Filed JAN 3 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1 1922

17 I HEREBY CERTIFY, That I attended deceased from August, 1921, to January 1, 1922, that I last saw h. e alive on Dec 31, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Colitis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Blandford, M. D.

1/1, 1922 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Jan 4 1922
20 UNDERTAKER	ADDRESS
Martin Bahey Sons	2276 North

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. Consult with attending physician if necessary. Any exceptional delay in filing this certificate is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

59877

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

101 D 59877

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 304 N. Exeter St

CITY OF BALTIMORE: (No. 304 N. Exeter ST., 5 WARD)

2-FULL NAME Eva Chavanett Chwatt

(a) RESIDENCE NO. 304 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, ~~or Divorced~~ (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	12	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Office

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Morris Chavanett (Chwatt)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dina Trapin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Dina Chavanett (Chwatt)

(Address) 304 N. Exeter St.

15 Filed JAN 3 + 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 2, 1922,

that I last saw her alive on Jan 2, 1922,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(write sudden [illegible] coma)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 12 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank J. Fuchs, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Rosedale — DATE OF BURIAL 1-3 1922

20 UNDERTAKER Jack Lewis, 1411 E. Baltimore St. — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59878

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 59878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Schulman

(a) RESIDENCE. No. 2946 Parkwood Ave. ST.: ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 2, 1922.

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day 6 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mercy Hosp. Balto. Md.

PARENTS

10 NAME OF FATHER: Oscar Schulman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Gertrude Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mercy Hosp. Records (Address)

15 Filed ..... 19 ..... Registrar

JAN 3 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922 to Jan 2, 1922.

that I last saw her alive on Jan 2, 1922.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(7 months gestation)

(duration) ..... yrs. (2) mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Weakness 6/24 hrs.

Failure (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Signs & Symptoms

(Signed) John A. Edgar M. D.

19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fitzw Friendship	1-3 1922

20 UNDERTAKER: Jack Lewis, ADDRESS: 14 N. E. Balto

CAUSE OF DEATH in plain terms, so that no other than a medical definition will be sufficient. Do not use abbreviations or initials. Do not state mode of dying, such as heart failure, asphyxia, or anemia, but the disease or injury which caused it. If from accident, violence, or casualty, state the nature of the accident, injury, or casualty, and whether it was accidental, suicidal, or homicidal. IF FROM ANY DISEASE OF A FEMALE, STATE WHETHER IT WAS CONTRACTED BY SEXUAL INTERCOURSE. IF FROM CHILDBIRTH, STATE WHETHER CHILD WAS BORN ALIVE OR STILLBORN. IF FROM ABORTION, STATE WHETHER SPONTANEOUS OR INDUCED. IF FROM ANY DISEASE PECULIAR TO INFANCY, STATE WHETHER LEGITIMATE OR ILLEGITIMATE. This information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59879

CERTIFICATE OF DEATH.

90 ✓

D 59879

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 18 East Cuter (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Howard Oakes

(a) RESIDENCE. No. 18 East Cuter St. 13 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hair Dresser

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: Hersch & Howard Co

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER James Oakes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Mary Nugent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Agnes Nugent.
(Address) 18 East Cuter

15 Filed JAN 3 - 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 - 1922

17 I HEREBY CERTIFY, that I attended deceased from Nov. 11, 1921. to Jan 1, 1922
that I last saw her alive on Dec. 31, 1921.
and that death occurred, on the date stated above, at 4 9 m.
The CAUSE OF DEATH* was as follows: Over

Aortic Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. F. Coughlin M. D.

1922 (Address) 3701 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	1/3/22
20 UNDERTAKER	ADDRESS
J. J. Fahey Sons	1318 Light St

CAUSE OF DEATH must be stated plainly, and as fully as possible. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic hemiplegia
Not fluctic

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59880

CERTIFICATE OF DEATH.

D 59880

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3139 Cedar ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Jones

(a) RESIDENCE. No. 3139 Cedar ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rose Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Georgia Canoles
(Address) 3139 Cedar ave

15 Filed JAN 3 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 30 1921 to Jan 1 1922, that I last saw her alive on Jan 1 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B. Lee Tragnesio M. D.

1, 2, 1922 (Address) 1706 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 4 1922
20 UNDERTAKER Johannah Canoles	ADDRESS 946 Lexington st

N. B.—WRITE PLAINLY. WITH LEAD PENCIL. PHYSICIANS' ATTENTION is called to the fact that every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful to see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 416 Fawcett St. 12 WARD)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Miller

(Residence in Baltimore: No. 416 Fawcett st St.: yrs., 5 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, July (Month) 26 (Day), 1921 (Year)

7-AGE, 5 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, Lester Miller

11-BIRTHPLACE OF FATHER (State or Country), MD

12-MAIDEN NAME OF MOTHER Louise Speddon

13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Miller

(Address) 416 Fawcett St.

15-

Filed....., 191.... C & G Registrar.

JAN 3 - 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John Morrison M. D.
(Coroner.)

1922 (Address) 5692 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden | DATE OF BURIAL, Jan 3 1922

20-UNDERTAKER Chenoweth & Donaldson | ADDRESS Pennsylvania ave

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

MARY S. WALL

D 59882

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

D 59882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 West Lafayette Ave. ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. Wall

(a) RESIDENCE NO. 1328 West Lafayette Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Wall

6 DATE OF BIRTH (month, day, and year) Sept. 25th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	87	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Westminister Md.

PARENTS

10 NAME OF FATHER John McCollum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. A. Wall
(Address) 1328 W. Lafayette Ave

15 Filed JAN 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 , 1921 , to Jan 1st , 1922 ,
that I last saw h alive on Jan 1st , 1921 ,
and that death occurred, on the date stated above, at 1 05 A. m.
The CAUSE OF DEATH* was as follows:

Influenza

(duration) , yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W. R. Lucier ....., M. D.

1/3, 1922 (Address) 614 E. Camden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emory Chapel Carroll Co Md.	Jan 4 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. THIS INFORMATION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 59883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59883

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 229 N. Poppleton ST., 18 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Myers

(a) RESIDENCE. No. 229 N. Poppleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	3	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Lizzie Walters
(Address) 4 E. Collington Ave

15 Filed JAN 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1921, to Jan 1, 1922, that I last saw h[er] alive on Dec 31, 1921, and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Organic Heart Disease
(Valvular Heart disease)
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Diagnosis

(Signed) Paul Brown, M. D.
(Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	1-3 192[illegible]
20 UNDERTAKER H. C. Brenning Son	ADDRESS 1711 E. Lombard St

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59884

CERTIFICATE OF DEATH.

101-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 E. 20 St. St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen A. Newman

(Residence in Baltimore: No. 1002 E. 20 St St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Feb. (Month) 14 (Day), 1853 (Year)

7-AGE, 68 yrs. 10 mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country). New London Conn.

PARENTS.

10-NAME OF FATHER. William Airy

11-BIRTHPLACE OF FATHER (State or Country) New London Conn.

12-MAIDEN NAME OF MOTHER. Belinda Marks

13-BIRTHPLACE OF MOTHER (State or Country). France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie A. Brannan

(Address) 1002 E. 20 St

15- Filed JAN 3 - 1922, 191..... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CAUSE OF DEATH. This information is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 30 1921, to January 2 1922, that I saw her alive on January 2 1922, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. A. Millman M. D.

Jan 3., 1922 (Address) 2 West 20 st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St Mary's Hanover Pa. DATE OF BURIAL, Jan 6, 1922

20-UNDERTAKER A. S. Marshall ADDRESS 357 Park Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59885

CERTIFICATE OF DEATH. — 49

D 59885

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Beechfield ST. Beechfield Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Morsell Hopkins

(a) RESIDENCE No. Beechfield ST. Beechfield Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 - 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	20	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Robert D. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Isabel Luke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Isabel Luke Hopkins (Address) Beechfield ave

15 Filed JAN 3 - 1922 ROBERT B. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Janu 2 1922

17 I HEREBY CERTIFY, That I attended deceased from December 4th, 1921, to January 1st, 1922, that I last saw h'm alive on January 1st, 1922 and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of the right testicle, with Secondary metastases to the lungs and liver.

(So far as I know) (duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (following the anesthesia)

(duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death? First discovery of tumor of testicle in July, 1922, while in Baltimore, during College Vacation. Pneumonia developed at Phipps Sanitarium

Did an operation precede death? Yes Date of December 11th, 21

Was there an autopsy? No Tumor of testicle was removed for diagnosis & aid in dosage of Roentgen Therapy.

What test confirmed diagnosis? Microscopic exam of Sections of testicular tumor. Pneumonia by clinical Signs.

(Signed) Thomas B. Futcher, M. D.

Jan 2, 1922 (Address) 1129 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Janu 4 1921

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 N. Fayette St

mation should be given, so that it may be properly coded.
CAUSE OF DEATH in plain terms, so that it may be properly coded.
TION is very important. See instructions on back of certificates.

HALL

D 59886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59886

CERTIFICATE OF DEATH.

113

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1714 Lorman ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Hall

(Residence in Baltimore: No. 1714 Lorman St. St.; yrs., 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, August 25, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....none....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Julius Kigler

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Irene Hall

13-BIRTHPLACE OF MOTHER (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene Hall

(Address) 1714 Lorman St.

15-

Filed JAN 3 1922, 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit ....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 1, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardio-colitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....) T. F. Hennessy M. D.
(Coroner.)

Jan. 2, 1922 (Address) 2882 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Jan 4, 19 22
20-UNDERTAKER	ADDRESS
Paul R. Dehn	303 Freeman

N. B.—Every item of information must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Stone—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59887

CERTIFICATE OF DEATH.

D 59887

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1401 Calhoun (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Palmer

(a) RESIDENCE. No. 1401 Calhoun St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Horace Palmer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Hemsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Horace Palmer
(Address) 1401 Calhoun St.

15 Filed JAN 3 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/11 1921 to 12/31 1921, that I last saw h— alive on 12/31 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Burkett, M. D.

1922 (Address) 2134 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan. 3 1922
20 UNDERTAKER Penn & Dennis	ADDRESS 1393 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59888

CERTIFICATE OF DEATH.

X 10

D 59888

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 2517 N. Charles St. (Hospital) 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna S. Jones

(Residence in Baltimore: No. 2517 N. Charles St.; yrs., 1½ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Aug (Month) 5 (Day), 1887 (Year)

7-AGE 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 937

9-BIRTHPLACE, (State or Country). New Jersey

PARENTS.

10-NAME OF FATHER Charles Shaw

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Lenkins

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Kay Jones

(Address) 2517 N. Charles

15- JAN 3 - 1922 ROBERT R. KRAUTER

Filed ..... 191 ..... Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 1st (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Jan 2 1922 (Address) 343 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Melvale N.J.	1/4 ....., 1922
20-UNDERTAKER William Cook per F. J. McCarthy	ADDRESS 502 North Ave

I. B. Every answer must be plain and full. Each question must be answered. Physician or other person certifying CAUSE OF DEATH must state it in plain terms, so that it may be properly classified. Each statement important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

✓ Dr Athey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59889

CERTIFICATE OF DEATH.

38 D 59889

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 109 E. Boulding St. ST., 7th WARD)

2-FULL NAME William F. Staps

(a) RESIDENCE No. 109 E. Boulding ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Staps

6 DATE OF BIRTH (month, day, and year) Oct 17-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Standard Oil Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Staps.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cristina Dommar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Clara Holtz.
(Address) 109 S. Boulding St.

15 Filed JAN 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1921, to Jany 1st, 1922, that I last saw him alive on Jany 1st, 1922, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Paresis TRW

(duration) yrs. 2 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Cobb N Athey, M. D.

May 2 1922 (Address) 100 S Potomac Pontiac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Jan 4. 1922

20 UNDERTAKER H. Sandos Sons ADDRESS 210 Park St

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilitic

Bessie L. German ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1449 D 59890

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Eastern Ave ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie L German

(a) RESIDENCE. No. 1816 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew German

6 DATE OF BIRTH (month, day, and year) Aug. 11th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md.

PARENTS

10 NAME OF FATHER John T. Pedvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Virginia Keighton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md.

14 Informant Andrew German
(Address) 1816 Eastern ave.

15 Filed JAN 3 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/1, 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/31, 1921, to 1/1/22, 1922

that I last saw h alive on 1/1, 1922,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Dyspnea (respiration), Fatty degeneration of heart, & Endocarditis

(duration) yrs. 17 mos. ds.

CONTRIBUTORY (Secondary) heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jno N Coulter, M. D.

1/1, 1922 (Address) 1023 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Jan. 3rd 1922
20 UNDERTAKER	ADDRESS 115
E. H. Harle	E. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 59891

REGISTERED No. C

59891

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 832 E. Pratt St ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Stewart.

(Residence in Baltimore: No. 832 E Pratt St St.; 47 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ....., (Day) 1879 (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... O'H

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Stewart

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Emma Eckert

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Stewart

(Address) 715 Gough St

15-

Filed JAN 3 - 1922 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 1, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Theodore Steiner M. D.
(Coroner)

Jan 2 1922 (Address) 1500 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, Jan. 4, 1922

20-UNDERTAKER Wm Cook

ADDRESS 502 E North

N. B. Enter in CAUSE OF DEATH in plain terms, so that it may be properly classified. Each answer is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 59892
15,2808.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

37 D 59892
REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 10 WARD)

2-FULL NAME Charles Chaplin.

(a) RESIDENCE. No. 615 N. Central Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~: Julia Brown (mother in law)
1104 E. Lexington St. City.

6 DATE OF BIRTH (month, day, and year): Dec. 22, 1883

7 AGE: 38 Years — Months 9 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stevedore. 674
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer
(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10 NAME OF FATHER: Robert Chaplin
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Julia Brown 1104 E. Lexington St. Records.

15 Filed JAN 3 - 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1921, to Dec. 21, 1921, that I last saw him alive on Dec. 21, 1921, and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure
Chronic

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Aortic insufficiency.
(duration) yrs. unknown mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of ——
Was there an autopsy? Yes
What test confirmed diagnosis? None

(Signed) Francis R. Dieudonné M. D.
Jan. 1, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel
DATE OF BURIAL: Jan 3 1922

20 UNDERTAKER: Mrs R A Elliott
ADDRESS 1725 Ashland Ave

CAUSE OF DEATH to plainly written or typewritten. Causes on back of certificates. TION is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should he taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contrihutory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contrihutory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly luetic in origin

D 59893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59893

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U. S. Infirmary ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Finney Gray

(Residence in Baltimore: No. a.a.co. (Maryland) Md. St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH, Dec. 31, (Month) (Day) 1856 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer): Md

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Stephen Gray.

11-BIRTHPLACE OF FATHER (State or Country) a. a. Co, Md

12-MAIDEN NAME OF MOTHER Sarah Jacobs

13-BIRTHPLACE OF MOTHER (State or Country), a.a. Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs William T Brierly

(Address) 738 N. Fulton Ave

15-

Filed JAN 3 - 1922 191 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 31, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) auto - accident

(Duration) yrs. mos. ds.

(Signed) D. C. T. Hennessy M. D. (Coroner) (Address) 2002 Eutaw Pl. Dec. 31, 1921

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death U.P.I. yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Mental & Nervous Dis.

Former or usual residence a. a. Co. (Maryland) Md.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mayothy Church Cemetery a.a.c.	Jan. 3, 1922
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

N. B. Every item of DEATH in plain terms, so that it may be properly CLASSIFIED. CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 59894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 59894

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 Hackberry Place ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F Manthei

(a) RESIDENCE NO. 1639 Hackberry Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 2 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales 040

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Tob Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herman Manthei

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria M Kriewald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman Manthei
(Address) 1639 Hackberry Place

15 Filed JAN 3 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1921, to Jan 2, 1922.

that I last saw him alive on Dec 22, 1921.

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted, if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. A. Sturhahn M. D.

1/3, 1922 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Jan 5 1922

20 UNDERTAKER John H Denny

ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 59895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59895

CERTIFICATE OF DEATH.

REGISTERED No. C 179

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Nmersity Hoopeletl ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lea Bear

(Residence in Baltimore: No. 874 W Balto St.

St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, unknown 1849
(Month) (Day) (Year)

7-AGE, 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L Baer

(Address) 874 W Balto St

15-

Filed JAN 3 - 1922 191 G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 1, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said (Inquest, au~~topsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body
(Duration) a few hours

CONTRIBUTORY (Secondary) Accident
(Duration) a few hrs

(Signed) J K Gorman M. D.
(Coroner.)

1-2, 1922 (Address) 112 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Auburn Cemetery — DATE OF BURIAL, Jan 3, 1922

20-UNDERTAKER J Fenwick Bur — ADDRESS 1127 E Balto St

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact important. See instructions on back of certificate.

Clothes caught fire while lighting gas stove

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

2

Spec. 4-20-1917—75M—2 Cys.—1000 Bks.

D 59896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59896

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: No. Esplanade Apts. ST.: Eutaw Place and Brookdale Lane WARD: 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac M. Stern

(a) RESIDENCE No. Esplanade Apts ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1859

7 AGE — Years: 62 — Months: 1 — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): dry goods.

(c) Name of employer: Merchant

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Morris Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Sallie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: A. M. Stern
(Address): Esplanade Apts.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from November, 1920, to Jan. 2, 1922, that I last saw h[im] alive on January 2, 1922 and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) 1 (one) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Nov. 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation + clinical

(Signed) J. Frederick Lentz, M. D.

1922 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom Cem. — DATE OF BURIAL: Jany 4 1922

20 UNDERTAKER: David Sandheim — ADDRESS: 1818 W. Baltimore

CAUSE OF DEATH in plain terms, so that a non-medical person may understand it. See reverse side for additional space. Also see instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 59897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59897

CERTIFICATE OF DEATH.

REGISTERED NO. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST.: 14 (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Flora Fine

(a) RESIDENCE. No. 1812 Division ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Fine

6 DATE OF BIRTH (month, day, and year) 8-22-71

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Samuel Cohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Pauline Baer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Records

15 Filed , 19 Registrar

JAN 3 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2 1922

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1921, to 1-2, 1922, that I last saw h alive on 1-2, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Fundus Uteri

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1919

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Brody, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Wash Road	Jan 3 1922

20 UNDERTAKER Jack Levin ADDRESS 1411 E Baltimore

CAUSE OF DEATH must be stated plainly. Supply all items. Omissions cause delay. Use ink. Write plainly. Do not use abbreviations. Do not write on back of certificates. ATTENTION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Blks.

152773 ✓

~~D 59898~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D 59898

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Newman.

(a) RESIDENCE. No. 1224½ E Fayette St City

(Usual place of abode) Unknown.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Annie Newman (Mother)

6 DATE OF BIRTH (month, day, and year) Aug. 9th ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15.	4.	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Myer Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Friedburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Records.

15 Filed JAN 3 - 1922, 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1922 to Jan. 1, 1922

that I last saw him alive on Jan. 1, 1922

and that death occurred, on the date stated above, at 11.22 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Rheumatic Heart disease

(duration) 6 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? 1224½ E Fayette St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Carlos Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Hebrew Cem	Jan 3 1922

20 UNDERTAKER	ADDRESS
Jack Leurs	1411 E Baltimore St

CAUSE OF DEATH to be filled in plain terms. Abbreviations must not be used. Information required by this certificate is necessary for the protection of life and property. Every item should be carefully considered and answered. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59899

CERTIFICATE OF DEATH.

QV D 59899

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Stafford Hotel (St.) 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wallis Pope

(a) RESIDENCE. No. 813 N. Charles St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced (or) WIFE of Micajah Pope

6 DATE OF BIRTH (month, day, and year) June 6th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady at Home.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Portsmouth N. H.

PARENTS

10 NAME OF FATHER George Tucker

11 BIRTHPLACE OF FATHER (city or town) Portsmouth (State or country) N. H.

12 MAIDEN NAME OF MOTHER Mary Wallis

13 BIRTHPLACE OF MOTHER (city or town) Portsmouth (State or country) N. H.

14 Informant Micajah W. Pope (Address) 813 N. Charles St.

15 Filed JAN 3 - 1922, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1901, to Jan. 1st 1922, that I last saw h[illegible] alive on Oct 15th 1921, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Sclerosis of Coronary artery with Thrombosis

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm M. Dabney, M. D.

Jan 1. 1922 (Address) Ruxton Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boston Mass	1-3 1922

20 UNDERTAKER Geo. E. Jenkins & Sons Co. ADDRESS McCullough Orchard

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificates. TION is very important.

D 59900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59900

CERTIFICATE OF DEATH.

REGISTERED No. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lapsley Hospital ST.: 5 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Timson

(Residence in Baltimore: No. 314 N Eden St.) (Age 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
Mal	col	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1898 (Year)

7-AGE,	If LESS than 1 day,
24 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laber
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Charles Timson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Gilbert

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore Timson

(Address) 314 N Eden st

15- Filed JAN 3 - 1922, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Knox Cooley M. D. (Coroner)

1-3, 1922 (Address) 4 E Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn	1-3-22
UNDERTAKER	ADDRESS
P C Lloyd	1406 W Eldorado

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59901

CERTIFICATE OF DEATH.

D 59901

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary WARD)

2-FULL NAME Mrs. Anna E. Townsend

(a) RESIDENCE NO. Reynolds Va. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1st 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo Wallace

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Anna Bruff

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mrs Louis Bowen
(Address) 322 E Third St

15 Filed JAN 3 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2. 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1921, to Jan 2 1922.
that I last saw her alive on Jan 2, 1922,
and that death occurred, on the date stated above, at 11:40 P.m.
The CAUSE OF DEATH* was as follows:
Diabetes mellitus.

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of
Was there an autopsy?.....
What test confirmed diagnosis? Laboratory test.
(Signed) Keith & Rice, M. D.
, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reynolds Va — DATE OF BURIAL Jan 3rd 1921

20 UNDERTAKER Peter Nicolaus — ADDRESS 2046 Eastern Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations must not be used. Diseases peculiar to females must be so stated. Contributory Causes must be stated. Duration must be stated in every case. Name of Disease is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59902 | 10-911 | D 59902

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Mc Henry St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William D. Beadenkopf

(Residence in Baltimore: No. 1614 Mc Henry St.; ....yrs., ...mos., ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH, March (Month) 7 (Day), 1859 (Year)

7-AGE, 62 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Steam fitter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Beadenkopf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Susan E. Kraft

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carroll W. Beadenkopf

(Address) 1612 Mc Henry St.

15-

Filed JAN 3 - 1922 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 31 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 28 1921 to Dec 31 1921, that I saw him alive on Dec 30 1921, and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

(a) Lobar Pneumonia

(Duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 10 ds.

(Signed) Henry C Wyatt M. D.

Dec 31, 1921. (Address) 1203 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Jan 3, 1922

20-UNDERTAKER Henry A Witzke

ADDRESS 1538 Monument St

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59903

CERTIFICATE OF DEATH.

10 D 59903

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 102 N Carlton ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Green

(Residence in Baltimore: No. 102 N Carlton 10 yrs St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	married

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, ...75.... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Green

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan ....

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Green

(Address) 102 N. Carlton

15-

Filed ....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of importance. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH. 1 A M

16-DATE OF DEATH, Dec. 31, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Indigestion
(Arm to diet)
(Duration) ..... yrs. ..... mos. 1 yr. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia
(Duration) ..... yrs. ..... mos. 1 6 ds.

(Signed) G. C. Wades M. D.
(Coroner.)
Jan 2, 191 2 (Address) 143 N. Stricker

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Richmond Station	Jan. 3, 1912

20-UNDERTAKER Mongan & Co. ADDRESS Edmonson Ave & 1403 Carey St

[illegible] for months.
No further history. Not cancerous

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 59904

CERTIFICATE OF DEATH.

D 59904

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Clarkson ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Parker

(a) RESIDENCE. NO. 1126 Clarkson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4ft 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — — 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) — 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Grace Holmes

(Address) 1126 Clarkson St.

15 Filed JAN 3 - 1922, 19.. ROBERT B. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2/1922

17 I HEREBY CERTIFY, That I attended deceased from 12/30/1921, to 1/2/1922, that I last saw her alive on 1/2/1922, and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical

(Signed) J. Gunby Brooks, M. D.

1/3/1922 (Address) 908 S Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 4 1922

20 UNDERTAKER J. W. Brown's Sons

ADDRESS 108 W. Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 59905 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59905

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Dennis

(a) RESIDENCE. NO. 925 China St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Jackson

11 BIRTHPLACE OF FATHER (city or town) Trenton.
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Trenton,
(State or country) New Jersey

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 1922

17 I HEREBY CERTIFY, That I attended deceased from December 15, 1921, to January 1, 1922, that I last saw her alive on January 1, 1922, and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows: Decubitus of back & legs

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) L. H. Brumbeck, M. D.

Jan. 3, 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Jan 4 1922

20 UNDERTAKER L. W. Brown & Son ADDRESS 1040 Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. ATION is very important. See instructions on back of certificates.

JAN 2 1922 ROBERT P. CHAMBERS. Local Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Of syphilitic origin.

D 59906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1622 ✓

D 59906

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 107 n Caroline St.; 6 WARD)

2-FULL NAME Thomas A Metzger

(Residence in Baltimore: No. 107 n Caroline St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	White	Boy

6-DATE OF BIRTH, Dec 27, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 640

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Frank Metzger

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mary Hinkelmann

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Metzger

(Address) 107 N. Caroline St

15- Filed JAN 3 - 1922 401 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) L. Engleman M. D.
(Coroner.)

1-3-22, 191.. (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. | DATE OF BURIAL, Jan 3rd, 1922

20-UNDERTAKER Lilly & Fuller | ADDRESS 403 E Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59907 ✓ D 59907

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 Westwood Ave. ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Adams Snyder

(Residence in Baltimore: No. 1801 Madison Ave. St.: 85 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, January (Month) 25 (Day), 1837 (Year).

7-AGE,	If LESS than 1 day,
85 yrs. 11 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 880

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John D. Adams

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Elizabeth Dugan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie E. Snyder

(Address) 2004 Eutaw Place

15-

Filed....., 191.....

Robert F. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 1st (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1921, to Jan. 1st 1922, that I saw h[illegible] alive on Jan. 1st 1922, and that death occurred, on the date stated above, at 9.20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

Uremia (Duration) yrs. 3 mos. ds.

(Signed) Vernon H. Gordon M. D.

, 191... (Address) 750 W. Mt. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Jan. 4, 1922
20-UNDERTAKER	ADDRESS
Wilbur W. Shivers	918 Edmondson Ave

Important. See instructions on back of certificate.

JAN 3 1922

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59908

001

161

D 59908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.; 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby of Earnest & Lula Fowler

(a) RESIDENCE. NO. 1612 E. Eager ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6 DATE OF BIRTH (month, day, and year): Jan. 2, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... Hrs. or 40 min.
0	0	0	0	10 Hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Earnest Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lula Lanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Ernest Fowler 1612 E Eager St

15 Filed JAN 3 - 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1922, to Jan 3, 1922, that I last saw her alive on Jan. 2, 1922, and that death occurred, on the date stated above, at 1.55 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Helen Vincent, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Jan 4 1922

20 UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59909

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 59909

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1814 W. Fayette ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Phipps

(a) RESIDENCE. NO. 1814 W. Fayette ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married,~~ Widowed, or ~~Divorced~~ (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Phipps

6 DATE OF BIRTH (month, day, and year) April 10 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Stube

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Treibel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) R. C. Phipps 1814 W. Fayette St

15 Filed JAN 3 1922 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922 to Jan 2, 1922

that I last saw h alive on Jan 1, 1922

and that death occurred, on the date stated above, at 3 40 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? clinical

(Signed) Bernard Schmidt, M. D.

19 (Address) 1715 Eutaw [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 4 1922

20 UNDERTAKER ADDRESS

for Foerderer's Son 2178 E. Pra

CAUSE OF DEATH in plain terms, as much as possible. Name of disease alone is not sufficient. Do not use abbreviations. Be sure to answer all questions. Information is required by law. Read carefully the instructions on back of certificates. TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

D 59910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59910

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Guilford Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Bielefeld

(a) RESIDENCE NO. 2400 Guilford Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Irving

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Herman E. Bielefeld 2405 Guilford Ave

15 Filed 3-1922, 19 Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1922, to Jan 2, 1922, that I last saw h-r alive on Jan 2, 1922, and that death occurred, on the date stated above, at 1115 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Walter A Day M. D.

1-3-1922 (Address) 5411 Fullerton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan. 4 1922

20 UNDERTAKER Joseph Byer

ADDRESS 1600 N Howard Ave.

mation should be entered in plain terms, so that it may be properly classified.
CAUSE OF DEATH is very important See instructions on back of certificates.
TION

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59911 D 59911

CERTIFICATE OF DEATH.

REGISTERED No. C 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 Roger St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Faustino Bory

(Residence in Baltimore: No. 2121 Roger St St.; 52 yrs., 10 mos. 28 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. February 4, 1871.
(Month) (Day) (Year)

7-AGE, 50 yrs. 10 mos. 25 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist 031
(b) General nature of industry, business, or establishment in which employed (or employer): Shipyard

9-BIRTHPLACE, (State or Country) Balto. City Md

PARENTS.

10-NAME OF FATHER, Ferdinand Bory

11-BIRTHPLACE OF FATHER (State or Country), ~~Texas~~ Bischfeld Bavaria Germany

12-MAIDEN NAME OF MOTHER Dorothy Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Wurzburg Bavaria Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Bory

(Address) 2121 Roger St

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2nd, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1922, to Jan 2 1922, that I saw h~~im~~ alive on Jan 1st 1922, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ....yrs. ....mos. 1 ....da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....da.

(Signed) Alfred A. Goodrich M. D.

Jan 2..., 1922 (Address) 5 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Jan 4, 1922

20-UNDERTAKER John J. Neer ADDRESS 156 N. Eutaw

(Windfelder)

D 59912 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59912

88

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 645 S. Curley - ST.) WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresa M. Windfelder

(Residence in Baltimore: No. 3034 McElderry - St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nov. (Month) 27 (Day), 1861 (Year)

7-AGE, 60 yrs. 1 mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Anton

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Monica Balster

13-BIRTHPLACE OF MOTHER (State or Country), Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. Geo. Windfelder
(Address) 3034 Mc. Elderry St.

15-
Filed ....., 191.... Robert P. Harrison, Registrar.
JAN 3 - 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF HEATH* was as follows:
Endocarditis
(Duration) yrs. mos. 1 da.
CONTRIBUTORY (Secondary) Pneumonia
(Duration) yrs. mos. da.
(Signed) C. E. Blake M. D.
(Coroner.)
Jan 1 22, 191... (Address) 43 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. da. In the State yrs. mos. da.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Jan 4, 1922

20-UNDERTAKER Jos. J. Kerr | ADDRESS 156 N. Bruce ave.

N.B.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-2836 D 59913 — X 79 D 59913

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST.: 7 (Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Hodges

(a) RESIDENCE. No. Marion, Somerset Co. ST., WARD. Marion Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Maryland yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sadie Hodges

6 DATE OF BIRTH (month, day, and year) ? 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Moze Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Martha Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant (Address)

15 Filed , 19 Registrar

N8 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1921, to Dec 29th, 1921, that I last saw h[illegible] alive on Dec 29th, 1921, and that death occurred, on the date stated above, at 7½ a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema and Myocardial Insufficiency

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? Somerset Co. Maryland.

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Francis R. Dieuaide, M. D.

Dec. 29, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Marion Station Somerset Co Md	Jan 3 22
20 UNDERTAKER	ADDRESS
Jesse Adkins	224 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of death is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 59914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59914

CERTIFICATE OF DEATH.

10

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 E Monument St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Mason Jr.

(Residence in Baltimore: No. 1205 E. Monument St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, Jan (Month) 11 (Day), 1903 (Year)

7-AGE, 8 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer): 200

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, William B. Mason

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Bertha A. Smithsman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William B. Mason

(Address) 1205 E Monument

15-

Filed....., 191.....

Robert P. Garrett, Registrar.

JAN 3 - 1922 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 3 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1921, to Jan 3 1922, that I saw h[illegible] alive on Dec 31 1921, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Diphtheria Toxemia

(Duration)....yrs....mos....ds.

(Signed) Wm. L. Rideout M. D.

Jan 5, 1922. (Address) 33 E. Monument.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	Jan 4, 1922
20-UNDERTAKER Finkler Finkler & E.S.F.	ADDRESS 1739 E. Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59915

CERTIFICATE OF DEATH.

D 59915

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO. 161

CITY OF BALTIMORE: (No. ..... St.: 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hoffman

(a) RESIDENCE. No. Church Home & Inf. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1 / 1 / 22

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or 20 min.
			1	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Saml Hoffman

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Rothschild

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Clinical Asst & Mother
(Address)

15 Filed 1-3-1922, 19 Robert P. Harriett
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 / 2 1922

17 I HEREBY CERTIFY, That I attended deceased from 1 / 1922, to 1 / 2 1922

that I last saw he alive on 1 / 2 1922

and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY —
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical findings

(Signed) A B Blue M. D.

. 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.
TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 59916

D 59916

CERTIFICATE OF DEATH.

151

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 N Castle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Bell Butler

(Residence in Baltimore: No. 1925 N. Castle St.; yrs. 6 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. June (Month) 27 (Day), 1921 (Year)

7-AGE. yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Chas. Butler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary A. Jansek

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ....., 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

CAUSE OF DEATH to be filled in plainly. Use no abbreviations. Be particular and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Dec. 31 1921, that I saw her alive on Dec. 31 1921, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

.....

Atelectasis Cong.

(Duration) yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. 6 mos. 7 ds.

(Signed) C. Irving Joslin M. D.

Dec. 31, 1921. (Address) 23 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL. ....., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

1922

Burial Permit Clerk

187?10

Spec.—8-24-14—M. & T.—2000 Bks.

D 59917 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59917

151

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N. Ann ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Armstrong

(Residence in Baltimore: No. 206 N Ann St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec. 26, 1921
(Month) (Day) (Year)

7-AGE, ...yrs.....mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Ernest Armstrong

11-BIRTHPLACE OF FATHER (State or Country), N C.

12-MAIDEN NAME OF MOTHER Doris Short

13-BIRTHPLACE OF MOTHER (State or Country), N C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 31, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26 1921, to Dec. 30 1921, that I saw h[illegible] alive on Dec. 30 1921, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) Premature Birth 6 mos

(Duration).....yrs.....mos.....ds.

(Signed) M. Hayes M. D.

Dec 31, 1921 (Address) 1 W. Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health.
Per. Wm. E. WOODALL

CAUSE OF DEATH to be plainly written. All questions important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 59918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59918

53

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56
Fort McHenry Baltimore Md.

CITY OF BALTIMORE: (No. ..... ST., 24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Engle

Baltimore Md.

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	--	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor.

(b) General nature of industry, business, or establishment in which employed (or employer) ------

(c) Name of employer ---------

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrock Registrar
(Address) US. PHS. Hosp. #56 Balto. Md.

15 Filed ..... 19 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1921 to Dec. 31, 1921, that I last saw him alive on Dec. 31 1921, and that death occurred, on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:
Hodgkins Disease.

Sept. 26, /21 (duration) - yrs. - mos - ds.

CONTRIBUTORY (Secondary) -----
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinic report.

(Signed) Thomas R. Payne M.D.
12/31 1921 (Address) Thomas R. Payne Senior Surg, US. PHS. Hosp. #56 Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Jan 4 1922

20 UNDERTAKER L Fernandes

ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Particular attention is very important. See instructions on back of certificates.

Jesse Barney (over)

D 59919 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59919

167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Barney

(Residence in Baltimore: No. 760 W. Franklin St.; 66 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... Don't Know, 1 .....
(Month) (Day) (Year)

7-AGE, 66 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Violet Wright

(Address) 576 W. Cross St.

15-

Filed JAN 4 - 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

N. B. Each item must be answered in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned on body

..... (Duration) ..... yrs. a few hrs. mos. ds.

CONTRIBUTORY (Secondary) Accident

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Gorman M. D.
(Coroner)

1-2-, 192.. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Jan 4, 1922

20-UNDERTAKER John H. Toadvine

ADDRESS 142 Druid St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 59920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59920

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore Md

REGISTERED NO.

CITY OF BALTIMORE: (No. 633 Walpert Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME—Mrs. Emma E. Rose

(a) RESIDENCE. NO. 10 Rosedale Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of—Wm. H. Rose

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Peter Gontrum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ann Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant William H. Rose
(Address) #10 Rosedale Ave.

15 Filed JAN 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921 to Jan 3, 1922 that I last saw h[illegible] alive on Jan 2, 1922 and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 7735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cem	Jan 6 19 22
20 UNDERTAKER	ADDRESS
William Cook	701 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Katherine Thompson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59921

CERTIFICATE OF DEATH.

14-001

14-D 59921

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 831 E. Biddle St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Thompson

(Residence in Baltimore: No. 811 W. West St.

Lh mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Widowed

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE 58 years ....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-PARENTS. 9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, John Keil

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. C. Thompson

(Address) 740 W. Lexington St.

15- JAN 4 - 1922 191.....

Filed ROBERT H. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) H. Ross Cullen M. D.
(Coroner)

1-2-, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem't. DATE OF BURIAL, Jan 4, 1922

20-UNDERTAKER Williamson & Nelson ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59922

CERTIFICATE OF DEATH.

D 59922

91-002

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 805 Belmont Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann J. Auld

(a) RESIDENCE NO. 805 N. Belmont Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Auld.

6 DATE OF BIRTH (month, day, and year) Oct 24-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jos. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Harry Auld

(Address) 805 N Belmont Ave

15 Filed JAN 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27 1922 to Jan. 2 1922

that I last saw h er alive on Jan 1 1922

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmit M. D.

Jan 4 1922 (Address) 701 Aberdeen Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Jan 4 1922
20 UNDERTAKER Geo M. Frink & Son	ADDRESS 811 W Lex St

mation should be carefully written in plain terms, so that it may be properly classified. EACH CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59923

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

33 D 59923

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Municipal Hospital. ST.: 7 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Streeter Kesley

(a) RESIDENCE. No. 620 N. Bethel St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	28	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Oscar Kesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Agnes Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Hospital Records

(Address) Municipal Hospital

15 JAN 4 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1 1922

17 I HEREBY CERTIFY, That I attended deceased from September 14, 1921, to January 1, 1922, that I last saw him alive on January 1, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Remedy Abatement	Jan 4 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 59924

CERTIFICATE OF DEATH

D 59924

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

2-FULL NAME William J. Holt.

(a) RESIDENCE NO. 721 Kilsach Court. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 840

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bayview Hospital Baltimore, Md.

15 Filed JAN 4 - 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10 1920 to Jan 1 1922

that I last saw him alive on Dec 31 1921 and that death occurred, on the date stated above, at 12 35 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal) (duration) mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Fredenhall, M. D.

1/11 1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 4 1922

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Oakland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15734 59925

CERTIFICATE OF DEATH.

D 59925

129

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 7 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Murphy.

(a) RESIDENCE. No. 1012 N. Wolfe St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Louis Murphy.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 32. Months ?. Days ?. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H-Work 037

(b) General nature of industry, business, or establishment(in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER: Jeff Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Frances Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. Ca.

14 Informant (Address): Records

15 Filed JAN 4 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1921, to Jan. 2, 1922

that I last saw her alive on Jan. 2, 1922

and that death occurred, on the date stated above, at 6 50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Hepatitis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secundary) Uremia (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Chemistry

(Signed) Francis R. Dieuaide, M. D.

Jan., 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laural Cemetery — DATE OF BURIAL: Jan 4 1922

20 UNDERTAKER: Mrs Robert-A Elliott — ADDRESS 1725- Oakland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59926

CERTIFICATE OF DEATH.

31 D 59926

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 N Milton ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Fink

(a) RESIDENCE. No. 1203 N. Milton ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Grace M Fink

6 DATE OF BIRTH (month, day, and year) Jan 3 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) Meter Mfg

(c) Name of employer Maryland Meter Work

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Einolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Grace M Fink

(Address) 1203 N Milton ave

15 Filed JAN 4 1922 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1921, to Jan 3 1922

that I last saw h/m alive on Jan 2 1922

and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H F Hergood M.D.

1/3, 1922 (Address) 1305 N Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 5th 1922
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Drenhold

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59927 ✓ 193 D 59927

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5th and 18th St. (WARD)

2-FULL NAME Herman Drenhold

(Residence in Baltimore: No. 5th and 18th St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1847 (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ezekiel Fabius Latham

(Address) 3921 (Pikesville) Baltimore

15-

Filed ....., 191... ROBERT R. KRAUTER Registrar.

JAN 4 - 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otway Grant Cruser M. D.
Jan 3 22 (Coroner) (Address) 1554 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, Jan. 4, 1922

20-UNDERTAKER Jack Lewis ADDRESS 411 E. Baltimore St

N.B.—Every item of information should be carefully supplied. AGE must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 59928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 59928

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St., 3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Dora Sherman

(a) RESIDENCE NO. 235 Eden St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. Sherman

(Address) 5 E Chauncey Ave

15 Filed JAN 4 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-3 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 19 21, to Jan 3rd, 19 22,

that I last saw h alive on Jan 3rd, 19 22,

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Perforation of Gall Bladder
Peritonitis

1 yr.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema of Gall Bladder

(duration) 2 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 1/2/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Stolz Southheimer M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodelph Cem. DATE OF BURIAL: Jan 4 1922

20 UNDERTAKER: Jack Lewis 1411 E Balto St ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Stone in cystic duct which prevented gall bladder from emptying. Rupture of gall bladder

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59929

CERTIFICATE OF DEATH.

D 59929

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 101 Dorsey ST.: 15 WARD) REGISTERED No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. James Smith (Sallie)

(a) RESIDENCE. NO. 3219 Windsor Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White-Irish	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Smith

6 DATE OF BIRTH (month, day, and year) November 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Cunnea

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Katrine Padia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Butler.
(Address) 2018 Baker St

15 Filed JAN 2 1922, 19 Registrar

ROBERT R. KRAETER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1921, to Jan 2, 1922, that I last saw h[illegible] alive on Jan 2, 1922, and that death occurred, on the date stated above, at 10 [illegible] A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis; Myocardial insufficiency; Aortic & Mitral insufficiency.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray.

(Signed) Paul W. Sutton, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 5, 1922
20 UNDERTAKER	ADDRESS
John F. Cowan & Son / Est. P. F. Cowan	901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59930

CERTIFICATE OF DEATH.

90 D 59930

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 W. Henrietta ST.; 21 WARD)

2-FULL NAME Mary E. Worden

(a) RESIDENCE. NO. 439 W. Henrietta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mosie Wilson
(Address) 439 W. Henrietta St.

15 Filed JAN 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/1/1922

17 I HEREBY CERTIFY, That I attended deceased from 12/31/21, to 1/1/1922, that I last saw her alive on 1/1/1922, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

duration yrs. mos. ds.

CONTRIBUTORY (secondary) Mitral Regurgitation (duration) one yr 3 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lynn Barney, M. D.

, 19 (Address) 908 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 4 1922

20 UNDERTAKER Saml. B. Kemp ADDRESS 1118 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59931

CERTIFICATE OF DEATH.

109 D 59931

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital 9 St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Smith

(Residence in Baltimore: No. 17 Vincent St St.; 43 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1 (Year)

7-AGE, 43 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Spencer

11-BIRTHPLACE OF FATHER (State or Country), ? Md

12-MAIDEN NAME OF MOTHER Waggie Brown

13-BIRTHPLACE OF MOTHER (State or Country), ? Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Adams

(Address) 17 N. Vincent st

15- Filed JAN 4 - 1922, 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec - 31 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1922, to Dec 31 1922, that I saw h er alive on Dec 31 1922, and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

Intestinal Obstruction

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) ... yrs. ... mos. 2 ds.

(Signed) H. E. Warfield M. D.

Dec 31, 1922 (Address) Franklin Sq. Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 1 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? 17 Vincent St

Former or usual residence 17 Vincent St,

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Jan. 4, 1922

20-UNDERTAKER A. Jones 20 | ADDRESS S. Sluder st

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Lena Tyler Barclay)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59932

D 59932

CERTIFICATE OF DEATH.

90

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 728 Wyndhurst St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Tyler Barclay

(Residence in Baltimore: No. 728 Wyndhurst Ave St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, June 6, 1869
(Month) (Day) (Year)

7-AGE, 52 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country) Bowling Green Ky.

PARENTS.

10-NAME OF FATHER, David Tyler

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER Byrd Dickerson

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Lee Barclay

(Address) 728 Wyndhurst Ave

15- Filed JAN 4 - 1922 ROBERT R. KRAUTER, 101 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest on the body (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H. Mowry M.D. (Coroner.)

Jan 3 1922 (Address) 7632 Belair Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	1-4, 1922
20-UNDERTAKER Herbert Kuhn	ADDRESS Druid Hill & McCulloh Orchard

N.B.—Every item of information must be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59933

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 E Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane West

(a) RESIDENCE. NO. 2031 E Biddle ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Samuel M West

6 DATE OF BIRTH (month, day, and year) Oct 31 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	76	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Unknown Jesse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Bense

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Harry Jr West 2031 E Biddle st

15 Filed JAN 4 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1922

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1921, to Jan 3, 1922,

that I last saw her alive on Jan 2, 1922,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D F Herzog M D. M. D.

1/3, 1922 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 6 1922
20 UNDERTAKER	ADDRESS
Wm. C. Miller	2534 Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1803

188 D 59934

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Sigward

(Residence in Baltimore: No. 2128 Wilkins Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Jan 4th, 1902 (Month) (Day) (Year)

7-AGE. 19 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Printer
(b) General nature of industry, business, or establishment in which employed (or employer). 063

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William Sigward

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Mary Massel.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Sigward

(Address) 2128 Wilkins Ave

15- Filed JAN 4 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 25th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mutilation Brain 1 hr
Lacerations (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.

(Signed) H. C. Steele M. D.
(Coroner.)
Jan 25 1922 (Address) 1437 E Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral

DATE OF BURIAL. 1-5-1922

20-UNDERTAKER. James Dignan & Son

ADDRESS 1000 S Paca St

N. B.—Every item of information called for in this certificate should be properly answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 59935

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2204 E Pratt (St.:) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margeret Damitz

(a) RESIDENCE (Usual place of abode) No. 2204 E Pratt St., Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 18 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Damitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rose Pistar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Damitz (Address) 2204 E Pratt

15 Filed JAN 4 - 1922 19 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 — 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec- 30, 1921, to Jan 3 —, 1922, that I last saw h— alive on Jan 3 1922 and that death occurred, on the date stated above, at 5 15 P m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia — ORR

(duration) yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Mark A Bonar, M. D.

, 19 (Address) 125 E Baltimore —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 5 1922
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PROFESSION should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59936

CERTIFICATE OF DEATH.

101-001

D 59936

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 166 Collins Av ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Armstrong

(a) RESIDENCE. NO. 166 Collins Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Armstrong

6 DATE OF BIRTH (month, day, and year) April 3 1881

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coach Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry

(c) Name of employer with Pelus Engine Works

9 BIRTHPLACE (city or town) (State or country) Wilmington Del

PARENTS

10 NAME OF FATHER John Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmington Del

12 MAIDEN NAME OF MOTHER Emma Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington Del

14 Informant Cora Armstrong (Address) 166 Collins Ave

15 Filed JAN 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1921, to Jan 3, 1922, that I last saw him alive on Jan 2, 1922, and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard Jones, M. D.

Jan 4, 1922 (Address) Juvenile Court

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	1/6 19 22
20 UNDERTAKER J. B. Hoffman	ADDRESS 2226 Eutaw Pl

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59937

CERTIFICATE OF DEATH.

135 D 59937

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 Somerset ST.; 5 WARD)

2-FULL NAME Jacob Thompson

(a) RESIDENCE. No. 434 Somerset ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred over 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Thompson

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	60	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer 64

(b) General nature of industry, business, or establishment in which employed (or employer) Anything

(c) Name of employer Balt. & Ohio R.R.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Daniel E. Hollis
(Address) 440 Somerset St

15 Filed JAN 4 - 1922 ROBERT E. HUNTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 Jan 1922

17 I HEREBY CERTIFY, That I attended deceased from 30/12/ 1921 to 1 Jan. 1922 that I last saw him alive on 31 Dec. 1921 and that death occurred, on the date stated above, at 6.40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Cerebellar

about 1 week (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. several mos. ds.

18 Where was disease contracted if not at place of death? Balto, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Mayfield Boyce M. D.

1/1. 1922 (Address) 424 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan 6th 1922
20 UNDERTAKER	ADDRESS
Chas. H. Bailey	1421 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably enlarged prostate. Nongonococcic infection. Not tuberculous.

Spec.—1-10-21—M&T—1500 Bks.

D 59938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59938

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie J. Blackburn

(a) RESIDENCE NO. 440 E. 25th ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER David H Johnston

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Arden

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Arthur H Blackburn
(Address) 440 E 25th St

15 JAN 4 - 1922 Filed ....., 19.... ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/31, 1921, to 1/2, 1922,

that I last saw her alive on 1/2, 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Acute Cardiac Dilatation

3 hours
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary Examination

(Signed) (Moses Gellman) M. D.

19 ..... (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	1/5/ 1922
20 UNDERTAKER E J Canning & Son 1938 E	ADDRESS Lafayette

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 59939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59939

CERTIFICATE OF DEATH.

REGISTERED No. C 24 184

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Howser. 34 St.; yrs., 5 mos., 14 ds.)

(Residence in Baltimore: No. 1737 Light St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 17th. 1887, 1 (Month) (Day) (Year)

7-AGE, 34 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Marine Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer): 130

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. James Howser.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Catherine Engelhart.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Howser. (mother)

(Address) 1737 Light St.

15- Filed JAN 4 - 1922, 191 ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31st. 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inqst (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) & Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage due to a fracture of the skull. struck in the mouth by fist and knocked down.

Homicide. (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... (Coroner.) M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Light & Barney Sts.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Jan. 4., 1922

20-UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light St.

N.B.—Every item of information should be carefully supplied. AGE should be stated in the largest terms possible, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59940

CERTIFICATE OF DEATH.

19 D 59940

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Rose Place ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Floyd Fortie

(Residence in Baltimore: No. 5781 W. Preston St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 12 (Day), 1885 (Year)

7-AGE, 36 yrs. 5 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Fortie

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lucy Murdock

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Murdock Fortie

(Address) 5781 W. Preston St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22, 1921, to Dec 31 1921, that I saw her alive on Dec 31, 1921, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

HRD

(Duration).....yrs.....mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Nephritis

(Duration).....yrs. 2 mos.....ds.

(Signed) W. Frank Boyd M. D.

Jan 2, 1922 (Address) 5781 W. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, 1-7-, 1922

20-UNDERTAKER Jno M. Johnson

ADDRESS 1234 Etting St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10,30

JAN 4 1922 ROBERT R. KRAMER
Burial Permit Clerk

Remarks

Chronic valvular heart trouble. No evidence of ptomaine poisoning. Heart condition primary cause

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59941

CERTIFICATE OF DEATH.

57 D 59941

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Knox

(a) RESIDENCE. No. 1003 Carrollton Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Abraham Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital

15 Filed JAN 4 - 1922 ROBERT R. KRAMER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from December 8, 1921, to Jan. 2, 1922, that I last saw her alive on January 1, 1921, and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary abscess

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

1/3/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan. 5 1922
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Eden St

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59942 ✓ D 59942

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Williams

(a) RESIDENCE. No. 924 Pear st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ----

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Veronica Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JAN 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1921, to Jan 2, 1922, that I last saw her alive on Jan. 2, 1922, and that death occurred, on the date stated above, at 7.27 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis Partagliard M. D.

1-3-22. 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	1/3/22 19
20 UNDERTAKER R.L. Parham	ADDRESS 649 W. Lee St.

mation should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Blks.

Wimbish

59943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 59943

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Wimbish.

(a) RESIDENCE. NO. 2[illegible] N. Fairfield Md ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 26th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 0[illegible]0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Bernard Cuson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Hattie Wimbish

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Records

15 Filed JAN 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible] to Jan. 3, 1922

that I last saw him alive on Jan. 3, 1922

and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Myocarditis?

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) H. B. Welch, M. D.

19 (Address) Harriet Lane Home.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chas. H. Stinson	Jan 4 1922
20 UNDERTAKER	ADDRESS
M. F. Auburn Cem.	416 N. Carolina

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

D 59944

HEALTH DEPARTMENT—CITY OF BALTIMORE

168-001 D 59944

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren Beeker—

(Residence in Baltimore: No. 615 Colombia ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male.	White	Married

6-DATE OF BIRTH. ..... Dont Know (Month) ....., 1 (Day) ..... (Year)

7-AGE. 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Dont Know

9-BIRTHPLACE. (State or Country). Dont Know

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER (State or Country). Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. M Routson

(Address) 230 N Greene

15- Filed JAN 4 1922 191.... ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... Dec. (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Inhalation

(Duration) ..... yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) H. H. Gorman (Coroner.) M. D.

1-4, 1922. (Address) 112 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Joliet Ill	Jan 7, 1922
20-UNDERTAKER W M Routson	ADDRESS 223 N Mt Street

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If UNDER 1 YEAR, or OVER 100 YEARS, the CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Went to sleep and gas stove not being properly adjusted. Man overcome. Sent to University Hosp

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Loborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59945

CERTIFICATE OF DEATH.

74-000

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 N. Spring ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ryan

(a) RESIDENCE. NO. 1610 N. Spring ST.. 9 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced ~~(of) HUSBAND~~ (or) WIFE of James Ryan

6 DATE OF BIRTH (month, day, and year) 9/15/1850

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
71	3	19	~~X~~

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) William Ryan 1610 N. Spring St.

15 Filed 1922 Robert P. Barrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1921, to Jan. 3, 1922, that I last saw her alive on January 2, 1922 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemiplegia of left side

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

1, 4, 1922 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	1/5/22 19

20 UNDERTAKER George J. Ruth. ADDRESS 1735 Harford Ave

AGE should be carefully supplied. All statements must be properly classified. Exact statement of OCCUPATION should be given. Write so that it may be plainly read. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N4

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic with terminal hemorrhage.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59946

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D 59946

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH 5

CITY OF BALTIMORE: (No. 520 N Charles ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louisa Gegan

(a) RESIDENCE. NO. 520 N Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed,~~ or ~~Divorced~~ (write the word)
Female	White	Single

5a If ~~married, widowed,~~ or ~~divorced~~
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
about 74				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Gegan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Sullivan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Mrs. Thomas C. Whelan
(Address) 300 N Calvert St

15 Filed 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1921 to Jan 4 1922
that I last saw h[illegible] alive on Jan 3d 1922
and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Victim of natural causes [illegible]

(Signed) Earl O'Brien M. D.

(Address) 5 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 5 1922

20 UNDERTAKER Henry A Jenkins & Sons Co

ADDRESS Orchard & Mc Culloh

APR 4 1922

---

mation should be carefully supplied. Attention is called to the fact that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59947

CERTIFICATE OF DEATH.

100-001

100 D 59947

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 East Lafayette ST., 14 WARD)

2-FULL NAME Azariah Shultz

(a) RESIDENCE NO. 318 East Lafayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug- 1837

7 AGE Years 84 Months 4 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (City or town) New York

(State or country)

PARENTS

10 NAME OF FATHER George Shultz

11 BIRTHPLACE OF FATHER (city or town) New York

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Brower

13 BIRTHPLACE OF MOTHER (city or town) New York

(State or country)

14 Informant Ethel M. Blackwell

(Address) 318 East Lafayette Av

15 Filed ..., 19 ... Registrar

Robert F. Harrison, Vital Report Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 4, 1922

that I last saw h[illegible] alive on Jan 3, 1922

and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry M. D.

, 19 (Address) 1142 North E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bath New York

DATE OF BURIAL 1-6th 1922

20 UNDERTAKER William Cook

ADDRESS 502 E North Ctn

N. B.—WHITE PAPER should be used. PENCIL should not be used. All information should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can bo ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably bronchs. No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59948

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH Bay view Hospital

REGISTERED NO.....

CITY OF BALTIMORE: NO..... ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R. Young.

(a) RESIDENCE. NO. 1930 Hanover ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37.			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Factory Imper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Bowers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bay View Hospital (Address) Baltimore, Md.

15 Filed ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

AN4 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 17, 1921, to Jan 3, 1922, that I last saw h[illegible] alive on Jan 3 1922 and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Status Epilepticus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Goldsmith, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	1-5th 1922
20 UNDERTAKER William Cook per F McCarthy	ADDRESS

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Exact statement of OCCUPA- may be properly classified. ck of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not luetic. No further history

Spec.—1-10-21—M&T—1500 Bks.

D 59949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59949

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 E Northern) (8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fowler

(a) RESIDENCE NO. 1811 E Northern St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male COLOR OR RACE White 4 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11 06

7 AGE Years 15 Months 1 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Alex B Fowler

11 BIRTHPLACE OF FATHER (city or town) Raleigh (State or country) N Carolina

12 MAIDEN NAME OF MOTHER Susan Lee

13 BIRTHPLACE OF MOTHER (city or town) Raleigh (State or country) N Carolina

14 Informant Alex B Fowler (Address) 1811 E Northern

15 Filed Jan 4 1922 Robert P. Harrison, Registrar

Selethia E. Eager Asst Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 31st, 19 21 to Jany 3rd 19 22

that I last saw him alive on Jany 3rd 19 22

and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

CDW

Acute Appendicitis

(Duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno S Flower, M. D.

Jany 4th 19 22 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Jan 5 1922

UNDERTAKER William Beck ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59950

CERTIFICATE OF DEATH.

90 D 59950

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 Main St. or Mt. Winans WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Hicks

(Residence in Baltimore: No. 4 Mains St. or Mt. Winans St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Aug 9, 1853
(Month) (Day) (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Lab

9-BIRTHPLACE, (State or Country) Balto Co Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Voss

(Address) Mt Winans

15- Robert P. Harrison,

Filed ..., 191...

Registrar.

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 3, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.)
I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. mos. ds.

(Signed) James M Fenton M. D.
(Coroner.)

Jan 4 1912 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, 1/6, 1912

20-UNDERTAKER William Woolf

ADDRESS, Sor & North Ave

Filed 1912 Burial Permit Clerk.

D Fenton Coroner's Clerk

T H Murphy

Spec. 1-10-21 M&T 1500 Blks.

Bornemann ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59951

CERTIFICATE OF DEATH.

114 D 59951

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5003 Chappanoke ST., road WARD) 27

2-FULL NAME J. H. Wm Bornemann

(a) RESIDENCE NO. 5003 Chappanoke ST., road WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Wh	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F.

6 DATE OF BIRTH (month, day, and year) Mch. 27, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	9	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Tailor Retired
(b) General nature of industry, business, or establishment in which employed (or employer) D80
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER J. H. W. Bornemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Steinmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant H. D. Bornemann
(Address) 5003 Chappanoke

15 Filed JAN 4 1922 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1921, to Jany 2nd, 1922, that I last saw h[illegible] alive on Jany 2nd, 1922, and that death occurred, on the date stated above, at 10, 30 P. m.

The CAUSE OF DEATH* was as follows:

Senile Cystitis Catarrhalis (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Asthenia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. S. Knee, M. D.

19 22 (Address) 1500 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Jan 5 1922

20 UNDERTAKER Frankenthal Funeral Co. — ADDRESS 1219 E. J. ?

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59952

CERTIFICATE OF DEATH.

D 59952

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: No. Lombard & Greene ST.; W WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jones

(a) RESIDENCE. No. Ellicott City Md ST.. WARD. Ellicott City Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (maid)

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alex Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rose Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant University Hospital Records (Address)

15 Filed Robert F. Harrison, Registrar

AN4 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1921, to Jan 11, 1922

that I last saw h.. alive on Jan 4, 1922

and that death occurred, on the date stated above, at 2.10 P m.

The CAUSE OF DEATH* was as follows:

Surgical Shock Own

.....(duration) .....yrs. .....mos. 4 Hrs.

CONTRIBUTORY (Secondary) Ruptured uterus -

.....(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 1-4-21

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

1-4-1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cem. Howard Co. Md.	Jan 7 1922
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

mation should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably gonorrhoea. Spontaneous rupture Uterus ~~t~~ with full term pregnancy. Abdominal section performed and dead child removed.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59953

CERTIFICATE OF DEATH.

66 D 59953

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 N. Caroline St. ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Duffy

(Residence in Baltimore: No. 210 N Caroline St St.; 66 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, Feb. 6 (Month), ... (Day), 1856 (Year)

7-AGE.	If LESS than 1 day,
65 yrs. 10 mos. 27 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Edward Duffy

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ellen Duffy

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Brown

(Address) 210 N. Caroline St.

15-

Filed JAN 5 1922, 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 3 (Month), ... (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 26, 1921 to Jan 3 1922, that I saw h[illegible] alive on Jan 3 1922, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

..... (Duration) 1 yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Delirium Tremens

..... (Duration) ..... yrs. ..... mos. 3 da.

(Signed) Richard J. Dobson M. D.

Jan 3, 1922 (Address) 1518 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Cemetery	Jan. 6, 1922
20-UNDERTAKER	ADDRESS
Chas. H. Johnson	216 N. Caroline St.

N. B.—Every item of information should be given as fully as possible. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59954

CERTIFICATE OF DEATH.

160 D 59954

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2239 W Lexington ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Margaret Knapp

(a) RESIDENCE. No. 2239 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo E Knapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma E Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Louisa M Knapp
(Address) 2239 W Lexington St.

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921, to Jan 4, 1922, that I last saw h[illegible] alive on Jan 4, 1922, and that death occurred, on the date stated above, at 2 00 P m.

The CAUSE OF DEATH* was as follows:

Tetanus Neonatorum

since Birth
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Her

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E Cuchman, M. D.

Jan 4, 1922 (Address) 2002 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	1/6 '22
20 UNDERTAKER	ADDRESS
Geo A Talley Sons	W Fayette

Should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59955

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Fannie Kelly

(a) RESIDENCE. NO. Philippi W. Va. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 18, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER M. V. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Elizabeth Hawbrooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Mercy Hospital Record
(Address)

15 Filed JAN 5 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1921, to Jan 5, 1922, that I last saw h[illegible] alive on Jan, 5, 1922, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Tumor in left broad ligament and infected tonsils

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis and Paralytic ileus (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 31, 1921

Was there an autopsy? no

What test confirmed diagnosis? Findings Signs & Symptoms

(Signed) John L. Edgar, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philippi W. Va	1/21/19
20 UNDERTAKER George A Farley	ADDRESS Fallon & Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tonsils removed and laparotomy done for tumor size of egg which on provd to be lymph gland microscopic exam. showing the lesions of Hodgkin's disease. No enlargement of other lymph glands was evident.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59956

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 59956

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. St.: 76 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna Stark

(a) RESIDENCE. NO. Unknown St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed JAN 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 1922

17 I HEREBY CERTIFY, That I attended deceased from September 14 1921, to January 3, 1922, that I last saw her alive on January 2, 1922, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 3 mos.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

1/3/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Jan. 5 1922

20 UNDERTAKER: Samuel Newbegin ADDRESS 578 Biddle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 59957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59957

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ross

(a) RESIDENCE. No. 1421 Brunt Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) -- 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	--	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler 070

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER --Jackson

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Vaughan

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Hospital Records
(Address)

15 Filed JAN 5 - 1922 J E Wilms Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 30 19 21, to January 2, 19 22, that I last saw him alive on Jan. 2, , 19 22, and that death occurred, on the date stated above, at 8:05 A m.

The CAUSE OF DEATH* was as follows:

Burns, first & second degree of face and hands. V V

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia & nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of --

Was there an autopsy? No.

What test confirmed diagnosis? Clinic & findings

(Signed) L H Brumbeck, M. D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Laurel Cem Jan 5 1922

20 UNDERTAKER — ADDRESS

Samuel Hensley 1921 N Dallas St.

Before Statistics are carefully supplied. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Burns from coal oil stove explosion

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152090 59958 — 90 D 59958

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.: 70 (WARD)

2-FULL NAME Charles Gaither

(a) RESIDENCE. No. 2431 Tristram ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A.

6 DATE OF BIRTH (month, day, and year): 12-1-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hair Spinner

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Edward Gaither

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Cristina Tanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lake Co Penna

14 Informant (Address): Records

15 Filed JAN 5 1922 19 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-3 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to 1-3, 1922

that I last saw him alive on 1-3, 1922

and that death occurred, on the date stated above, at 8.20 a m.

The CAUSE OF DEATH* was as follows:

Emphysema, Chronic myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) E. Bowles Hudnut, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae Cemetery	1/7 1922

20 UNDERTAKER: Henry H. Almacco X — ADDRESS: 4204 Ridgewood Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Zadorozny.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59959

CERTIFICATE OF DEATH.

161-001

D 59959

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Myrtle Ave St. 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zadarozney

(a) RESIDENCE. No. 1013 Myrtle Ave St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day 25 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Zadarozny

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Mercedes Tire

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Wm. Zadarozny
(Address) 1013 Myrtle Ave.

15 Filed JAN 5 - 1922 19... ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1922, to Jan 4, 1922, that I last saw him dead Jan 4, 1922, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asphyxia Neonatorum

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Institution.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) L. J. Rigney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 6 1922
20 UNDERTAKER	**ADDRESS**
John Grabliauskas	425 S. Paca St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of BOTH DATES is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59960

CERTIFICATE OF DEATH.

100,001

D 59960

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 N. Bruce st ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Elizabeth White

(a) RESIDENCE. NO. 1636 N. Bruce st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-4-20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1636 N. Bruce St. Baltimore, Md.

PARENTS

10 NAME OF FATHER Aaron White

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Goss

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Marie Goss (Address) 1636 N. Bruce St

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-20 1921, to 1-2 1921, that I last saw h e alive on 1-2 1921, and that death occurred, on the date stated above, at 10:04 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Rhachitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page M. D.

. 19 (Address) 1700 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	1/5 1922

20 UNDERTAKER Jno. Geo. H. Hooper ADDRESS 406 W. Conway St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 59961

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59961

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2103 Ridgewood Av. St.) (15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John H. Frisby

(Residence in Baltimore: No. 2103 Ridgewood ave St.) (66 yrs. Corean in md. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: April 4, 1856 (Month) (Day) (Year)

7 AGE: 65 yrs. 9 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: retired contractor
(b) General nature of industry, business, or establishment in which employed (or employer): of Homes 016

9 BIRTHPLACE (State or country): Prince George County Md

PARENTS

10 NAME OF FATHER: patrick Frisby

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget welsh

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Kathleen M Hebb

(Address) 2103 Ridgewood ave

15 Filed JAN 5 - 1922 191 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 5 th, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 15t 1921 to Jan 5 1922 that I saw him alive on Jan 4 th 1922 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Uremia (Duration) yrs. mos. 5 ds.

(Signed) Harris Goodman M. D.

Jan 5 1922 (Address) 1816 N north av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill DATE OF BURIAL: Jan 7, 1922

20 UNDERTAKER: Wm Cook, ADDRESS: 502 E. North

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59962

CERTIFICATE OF DEATH.

74-001 D 59962

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2441 Maryland AV ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Warner

(a) RESIDENCE NO. 2441 Maryland ST., 12 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	widow

3a If married, widowed, or divorced
HUSBAND of (or) WIFE of the late Wm S Warner

6 DATE OF BIRTH (month, day, and year) May 19 - 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78.	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimd

PARENTS

10 NAME OF FATHER Geo Kinsell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Chilcoat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Nannie Harnell
(Address) 2441 Maryland Ave

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1921, to Jan 4, 1922, that I last saw h-e alive on Jan 3, 1922, and that death occurred, on the date stated above, at 7-30 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe H Cross M. D.

Jan 4 1922 (Address) 2438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Jan 6 1922

20 UNDERTAKER Wm Cook — ADDRESS 502 E. North Av.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stock 6-1000 H. E. Co. 1009 Blks.

D 59963

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 159-001

D 59963

1524 5

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

2-FULL NAME Rupert A. Allen

(a) RESIDENCE. No. 674 Chestnut St. York, Pa, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 11th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Frank Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Edna M. Wiel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address)

15 Filed JAN 5 - 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1921, to Jan 4th, 1922, that I last saw him alive on Jan 4th, 1922, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) 3 yrs. 10 mos. 24 ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) L. E. Bandy, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York. Pa.	Jan. 5th 1922
20 UNDERTAKER Joseph Syfer	ADDRESS 160 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59964

CERTIFICATE OF DEATH.

90

D 59964

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) 17 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Cheesman

(a) RESIDENCE. No. 834 Bradley Av. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 25 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Cheesman

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Clayton David

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Cheesman
(Address)

15 Filed . 19 . ROBERT P. KRAUTER Registrar

JAN 5 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-4 1922

17 I HEREBY CERTIFY, That I attended deceased from 1-3, 1922, to 1-4, 1922

that I last saw her alive on 1-3, 1922

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompen

Patient general anasarca ?
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) F. A. Holden, M. D.

. 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	1/5/22 19
20 UNDERTAKER	ADDRESS
Jos. B. Pfeifer	Mulberry st

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59965

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 001

D 59965

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2503 Dulaney ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Shipley

(a) RESIDENCE. NO. 2503 Dulaney ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. J. Segar

6 DATE OF BIRTH (month, day, and year): Aug. 26 - 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	44	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Joseph Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Md

12 MAIDEN NAME OF MOTHER: Harriet Edmonson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md

14 Informant: George J. Segar
(Address) 2503 Dulaney St.

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Jan 3, 1922,

that I last saw h... alive on Jan 2, 1922,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Lord, M. D.

1922 (Address) 902 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 5 1922
20 UNDERTAKER: George L. Schwab	ADDRESS: 201 Bond Ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ACCIDENTS may be required. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59966

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

74 001 D 59966

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 & 21 St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles P. Riley

(a) RESIDENCE. No. 416 E. 21st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lily Riley

6 DATE OF BIRTH (month, day, and year) Sept 9-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr Riley—Son

(Address) 416 E. 21 St

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1921, to Jan 2, 1922, that I last saw h— alive on Jan 1, 1922, and that death occurred, on the date stated above, at 10.05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral - Haemorrhage

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph T. Herring, M. D.

Jan 5 1922 (Address) Walbrook 1802 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 5 1922

20 UNDERTAKER W M Routson

ADDRESS 2235 W Balto

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59967

CERTIFICATE OF DEATH.

89 D 59967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Hollins ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas R. Coleman

(a) RESIDENCE. NO. 1213 Hollins ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Alice Coleman

6 DATE OF BIRTH (month, day, and year): July 1844

7 AGE: Years 77 Months 6 mos. Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Francis Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Md

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Coleman

(Address) 625 Appleton st

15 Filed JAN 5 - 1922 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Jany 3, 1922, that I last saw h. alive on Jany 3, 1922, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos. hrs.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. A. O'Neill, M. D.

1/5, 1922 (Address) 108 N Bullitt Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 6 1922

20 UNDERTAKER: John J. Fallon — ADDRESS: 500 W Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1647 59968

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 720 St Peter St — ST.; 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H Cornthwaite

(a) RESIDENCE. No 720 St Peter St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired D16

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer + Builder

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robt Cornthwaite

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Martha Harrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Ella Conner

(Address) 720 St Peter St

15 Filed JAN 5 — 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1922, to Jan 4th, 1922

that I last saw h alive on Jan 4th, 1922

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) acute Indigestion + senility

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J Eppenbaum, M. D.

1/4/22 (Address) 65 Cleveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 7 1922
20 UNDERTAKER	ADDRESS
John J Cowan + Son	901 Hollins
per FJ Cowan	

mation should be carefully supplied. Age should be stated EXACTLY. Particulars as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No chronic organic heart trouble. Had eaten piece of nut cake which probably caused acute indigestion. Primary cause was hiss senility

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Broom St. & Madison Ave

CITY OF BALTIMORE: (No. Bellevue Manchester Apts. ST. 14 WARD)

2-FULL NAME Hannah Bacharach

(a) RESIDENCE NO. Bellevue - Manchester Apts. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 101 D 59969

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan A. Bacharach

6 DATE OF BIRTH (month, day, and year) Feb 22 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Isaac Jacobi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Caroline Jacobi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Oliver Bacharach (Address) Bellevue - Manchester

15 Filed JAN 5 1922 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 1919 to Jany 4 1922, that I last saw h[illegible] alive on Jany 3 1922, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Symptoms (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

I (Signed) Louis P. Hamburger M. D.

4 1922 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem

DATE OF BURIAL 1/6 1922

20 UNDERTAKER David Sonnheim

ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59970

CERTIFICATE OF DEATH.

161 D 59970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dietz.

(a) RESIDENCE NO. 1048 D. Dillon Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
1 day.	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 100

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Dietz

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mildred Harris

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922, to Jan 3, 1922, that I last saw him alive on Jan 3, 1922, and that death occurred, on the date stated above, at 10.50 p m.

The CAUSE OF DEATH* was as follows:

Atelectasis

Prematurity

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? Yes. H. Cattell

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Jan 5th 1922
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE mation should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1850 D 59971

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret L. Harrison

(a) RESIDENCE NO. 1739 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm. H. Harrison

6 DATE OF BIRTH (month, day, and year) Feb 14, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Grace Winkler

(Address) 1739 E. Eager

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from December 30, 1921 to Jan. 4 1922

that I last saw h alive on Jan. 4 1922

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

1 Broncho pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Fracture of upper end femur

(duration) yrs. mos 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Reduction of fract. Date of Dec. 31, 1921

Was there an autopsy? no

What test confirmed diagnosis? X-Ray

(Signed) Tom. J. Sachs M. D.

1922 (Address) The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Dec 6 1922
20 UNDERTAKER Frederick Winkler E. J. G.	ADDRESS 1738 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59972

CERTIFICATE OF DEATH.

D 59972

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 E. York ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Reynolds.

(a) RESIDENCE. NO. 111 E. York ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work — none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Reynolds

11 BIRTHPLACE OF FATHER (city or town) Port Limon
(State or country) Costa Rica.

12 MAIDEN NAME OF MOTHER Burial Permit Issued Bertha Heath

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Samuel Reynolds
(Address) 111 E. York St.

15 Filed JAN 5 - 1922 19 ROBERT R. KRAUSE Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to Jan 4, 1922,

that I last saw him alive on Jan 4, 1922,

and that death occurred, on the date stated above, at 3 00 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination

I, (Signed) L. J. Higgins, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	Jan 6, 1922

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 1114 N. Saratoga St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59973

CERTIFICATE OF DEATH.

154 - 00 ✓ D 59973

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St. Josephs Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Frauenhaus.

(a) RESIDENCE. No. 5303 Aberdeen ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-2-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	3	5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER G. L. Kauffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Md~~ Penn.

12 MAIDEN NAME OF MOTHER Gertrude R. Homan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant G. L. Kauffman
(Address) Hamilton

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4/1922

17 I HEREBY CERTIFY, That I attended deceased from 1/2/, 1922 to 1/4/, 1922

that I last saw h 2r alive on 1/4/, 1922

and that death occurred, on the date stated above, at 2 Pm m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No P. S. Symptoms

What test confirmed diagnosis?

(Signed) C C Smith, M. D.

, 19 (Address) 4706 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery.	Jan 5 1922

20 UNDERTAKER Lynch - L. Ruth ADDRESS 1735 Harford Ave

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59974

CERTIFICATE OF DEATH.

1929 D 59974

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Raborg ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rigby Warfield

(a) RESIDENCE NO. 714 Raborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of alice Warfield

6 DATE OF BIRTH (month, day, and year) ——— 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer D4D

(b) General nature of Industry, business, or establishment in which employed (or employer) B & O

(c) Name of employer Coal Pier Cambridge

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edith Warfield

(Address) 714 Raborg St.

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec, 30, 1921, to Jan, 3, 1922, that I last saw him alive on Jan, 2, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy (3rd attack)

1st attack 3 years ago

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis + chr. inter stitial nephritis (duration) unknown

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) David Franklin M. D.

1/3, 1922 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Jan 5 1922

20 UNDERTAKER David Carbin ADDRESS 916 Pine

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. It may be properly classified. TION is very important. See Instructions on back of certificates. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59975

CERTIFICATE OF DEATH.

31 D 59975

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—(No. 1913 Myrtle Av ST., 17 WARD)

2-FULL NAME Richard P. Green

(a) RESIDENCE NO. 1113 Myrtle Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE: Years 48 | Months | Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Savannah Ga.

PARENTS

10 NAME OF FATHER Alfred A. Green

11 BIRTHPLACE OF FATHER (city or town) Savannah (State or country) Ga.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Elizabeth (illegible) (Address) 420 N. Carline Av

15 Filed JAN 5 - 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922, to Jan 3, 1922

that I last saw h— alive on Jan 3, 1922

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Edema

Tuberculosis of Epiglottis

(duration) 9 mos

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. Parker Churchill M. D.

Jan 4, 1922 (Address) 1504 E. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cemetery — DATE OF BURIAL Jan 6th 1922

20 UNDERTAKER Chas S Bailey — ADDRESS 542 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59976

CERTIFICATE OF DEATH.

10

D 59976

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 East Preston St ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Kathleen Hayes

(a) RESIDENCE. No. 416 East Preston St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	----------

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 19. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John R. Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Cecilia M. Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John R. Hayes

(Address) 416 East Preston St.

15 Filed JAN 5 - 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1922, to Jan 5, 1922, that I last saw her alive on Jan 4, 1922, and that death occurred, on the date stated above, at 3.10 a m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno R. Quigley, M. D.

Jan 5, 1922 (Address) 1001 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/5/22 19

20 UNDERTAKER Henry W. Means & Son ADDRESS 801 N. Eutaw St.

N. B.—WRITE PLAINLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59977

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59977

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 828 N. Linwood St.: (Ward) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stumpf Jr

(a) RESIDENCE. NO. 828 N Linwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write word) (Married)

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Margaret Stumpf Jr

6 DATE OF BIRTH (month, day, and year) May 15 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): 1003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: John Stumpf Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mary Moehl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant (Address): Margaret Stumpf Jr 828 N Linwood Ave

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 4 1922

I HEREBY CERTIFY, That I attended deceased from Jan 3 1922 to Jan 4 1922.

That I last saw h[illegible] alive on Jan 4 1922.

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John R. Oruen M. D.

(Address) 35 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dallastown Cemetery — DATE OF BURIAL: May 6 1922

20 UNDERTAKER: Robt A Turner Inc — ADDRESS: 14 W Biddle

N. B.—WHITE SHEET. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E & C

D 59977 JAN 13 1922

C. Hampson Jones M.D
Commissioner of Health

Dear Sir

The social condi
of John Stumpfel was given as Single whe
He is the lawful Husband of Margaret Stumpfel
Signed by his sister in law,

Signed

Mrs. Minnie Stumpfel
814 N. Glover St.
City

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59978

REGISTERED NO. 11-002 D 59978

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2412 E. Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. E. Lee Fontes

(a) RESIDENCE. No. 2412 E. Oliver ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26th 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph De Fontes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Matilda Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph De Fontes (Address) 2412 E. Oliver St.

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1922, to Jan 5 1922,

that I last saw him alive on Jan 4 1922

and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

1/5 1922 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan. 6th 1922
20 UNDERTAKER Philip Herzog	ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 59979

REGISTERED NO.

10-22-17 59979

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST.: 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Calabrese

(a) RESIDENCE. No. 2828 E. Madison St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leon Calabrese

6 DATE OF BIRTH (month, day, and year) 2-16-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Angelo Pontera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Pontera

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Records.

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-3-1922

17 I HEREBY CERTIFY, That I attended deceased from 11-23, 1922, to 1-3, 1922; that I last saw h 2 alive on 1-3, 1922, and that death occurred, on the date stated above, at 12:35 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia, Empyema, Pneumonia Broncho, + Osteomyelitis

(duration) yrs. mos. 48 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 12/21 + 1/2/22

Was there an autopsy? yes

What test confirmed diagnosis? Blood culture Empyema Staphylococcus

(Signed) Geo. H. Gardner M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 7th 1922
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59980

CERTIFICATE OF DEATH.

14-001 D 59930

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 N. Luzerne Ave. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Meyer

(a) RESIDENCE. No. 435 N. Luzerne Av. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~the~~ WIFE of Kate Annie Meyer

6 DATE OF BIRTH (month, day, and year) Mar 18 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Geo. Goetz Sons

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Gertrude Dunkee

(Address) 536 N. Lakewood

15 Filed JAN 5 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1921, to Jan 5, 1922, that I last saw him alive on Jan 2nd 1922 and that death occurred, on the date stated above, at 5 20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell, M. D.

, 19 (Address) 15 S. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Jan. 6 1922
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS ENTIRE CERTIFICATE. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be of certificates. TION is very important. See instructions on back of ce

WRITE PLAINLY. WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 59981

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 59981

REGISTERED NO. C 129

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2400 W Lanvale ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Dittmar (Ret.: 38 yrs. 11 mos. 21 ds.)

(Residence in Baltimore: No. 2400 W Lanvale

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Jan (Month) 25 (Day), 1883 (Year)

7 AGE: 38 yrs. 11 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Bernhardt Wick

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosina Schneider

13 BIRTHPLACE OF MOTHER (State or country): Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Dittmar

(Address) 2400 W Lanvale St

JAN 5 - 1922 Filed 191

ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 4 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct ..... 1921, to Jan 4 1922.

that I saw h er alive on Jan 4 1922.

and that death occurred, on the date stated above, at 2.40 p m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis,

(Duration) 1 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) Marshall B Hurst M. D.

Jan 7, 1922 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Jan 7 1922

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 59982

74 D 59982

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Washington ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward B. Freeman

(a) RESIDENCE. No. 520 N. Washington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. Freeman

6 DATE OF BIRTH (month, day, and year): Feb. 8th 1851

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer): 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Anna M. Freeman

(Address) 520 N. Washington St.

15 Filed JAN 5 - 1922 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to June 4, 1922, that I last saw him alive on 11 3, 1922, and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Hardening of arteries

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. O. Hearn, M. D.

1/4, 1922 Address) 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Jan. 7th 1922
20 UNDERTAKER: Philip Herwig	ADDRESS 2016 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonin"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 59983

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Lery

(a) RESIDENCE. No. 134 N. Bond St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30th 1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sam Lery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Carman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant
(Address)

15 Filed JAN 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1922, to Jan 5th, 1922, that I last saw him alive on Jan 5th, 1922, and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Acute myocardial insufficiency

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H. St. Welch, M. D.

, 19 (Address) Harriet Lane Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt. Carmel	1-5 19

20 UNDERTAKER Jack Levin ADDRESS 1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Joseph.
Child came in Hospital one night & only history obtained was heart condition. No autopsy. No further history.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59984

CERTIFICATE OF DEATH.

167

REGISTERED NO. D 59984

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 4th WARD)

2-FULL NAME Baby Budelow

(a) RESIDENCE NO. 1726 N Broadway ST., ... WARD ...
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/3/22

7 AGE — Years: — Months: — Days: 1 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hebrew Hospital

PARENTS

10 NAME OF FATHER: Oscar Budelow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Ida Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa.

14 Informant: Hebrew Hospital
(Address)

15 Filed JAN 5 - 1922 19 ... ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/14/1922

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 1922, to 1/14, 1922.

that I last saw h alive on 1/14/, 1922

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

① Capital Hemorrhage

② Hemophilia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hemophilia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Julius Holzsomer, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL 1-5 1922

20 UNDERTAKER: Jack Travis — ADDRESS 1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59985

CERTIFICATE OF DEATH.

91-00

D 59985

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 S. Clinton ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Morgan

(a) RESIDENCE. No. 1309 S. Clinton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. - mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mollie Morgan

6 DATE OF BIRTH (month, day, and year) Dec. 27-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	-	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer D78

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Mollie Morgan
(Address) 1309 S. Clinton St.

15 Filed JAN 5 - 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 Jan 1922

17 I HEREBY CERTIFY, That I attended deceased from 28 Sept, 1921, to 3rd Jan, 1922, that I last saw him alive on 3rd Jan, 1922, and that death occurred, on the date stated above, at 8 a m m.

The CAUSE OF DEATH* was as follows:

Cerebral Softening

(duration) about 3 mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cardiac Pulmonary

(Signed) W. T. Mohr M. D.

, 19 (Address) 301 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Jan 6 1922

20 UNDERTAKER Zirkler & Zirkler Funeral

ADDRESS 1739 E. Eager St.

4.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not luetic. No cerebral hemorrhage.

D 59986 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59986

CERTIFICATE OF DEATH.

178

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St Joseph Hospital ST. 1 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Vangel
(Residence in Baltimore: No. 3113 Aliceanna St.) (If not in Baltimore, write the name of State or Country.)

St.: 39 yrs., —mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Sept. 7, 1858
(Month) (Day) (Year)

7-AGE: 63 yrs. 3 mos. 28 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Box Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Rosendorf Bx Co.

9-BIRTHPLACE, (State or Country): Germany

PARENTS.
10-NAME OF FATHER: Not known
11-BIRTHPLACE OF FATHER (State or Country): Not known
12-MAIDEN NAME OF MOTHER: Not known
13-BIRTHPLACE OF MOTHER (State or Country): Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elizabeth C. Vangel
(Address) 3113 Fleet St

15-
Robert P. Harrison,
Filed ....., 191.....
Special Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows: Burns. Burned on face and extremities
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
(Coroner)
6-5-, 191.2 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oaklawn cem
DATE OF BURIAL, Jan 7, 1912

20-UNDERTAKER Zukler & Zukler
ADDRESS 1739 E. Eager St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

115 1922

D 59987

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-007

D 59987

CERTIFICATE OF DEATH.

REGISTERED No. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1106 W. Cullok, St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver Dawnes Diggs

(Residence in Baltimore: No. 1106 W. Cullok St.: yrs., mos. 31 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Colored	Sing'l

6-DATE OF BIRTH, Dec. 2, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 3 d. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none
(b) General nature of industry, business, or establishment in which employed (or employer).....Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Richard Diggs

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Edith Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Dawnes

(Address) 1106 W. Cullok St.

15-

Filed Robert F. Carrigan, 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Organic heart disease

(Duration) ....yrs. ....mos. 31 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. T. Kenney M. D.
(Coroner.)

Jan. 5, 1922 (Address) 202 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL, Jan 7, 1922

20-UNDERTAKER Samuel Bundey ADDRESS Baltimore

JAN 5 1922 Burial Permit Issued

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Bks.

D 59988

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 59988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 John St. ST.; 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Maria Cane

(a) RESIDENCE NO. 1607 John ST., WARD 14th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1841-7-12

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	5	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Thomas Run, Harford Co. Md.

PARENTS

10 NAME OF FATHER: Matthew Cane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Thomas Run, Harford Co. Md

12 MAIDEN NAME OF MOTHER: Sarah Framer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): London, Eng.

14 Informant: Miss Fannie Corrigan

(Address): 1607 John St.

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1922 to Jan. 4, 1922

that I last saw her alive on Jan. 4. 1922

and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred M. Lorell M. D.

, 19 (Address) 2370 Liberty Hyde Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fannie Brae Cemetery

DATE OF BURIAL: Jan. 24 1922

20 UNDERTAKER: Martin Fahey & Son

ADDRESS: 822 W. N. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59989

HEALTH DEPARTMENT—CITY OF BALTIMORE

128

D 59989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Steele Road-Chapman Ave. ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Morrow Pugh

(a) RESIDENCE. No. Steele Road-Chapman Ave. ST., 27 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 61 yrs. 9 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eleanor Meyers Pugh.

6 DATE OF BIRTH (month, day, and year) April-2-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chemist.

(b) General nature of industry, business, or establishment in which employed (or employer): Chemistry.

(c) Name of employer: (self)

9 BIRTHPLACE (city or town) (State or country): Washington, D.C.

PARENTS

10 NAME OF FATHER: William J. Pugh.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Julia Morrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant: Mrs. Eleanor M. Pugh, (wife)
(Address) Steele Road and Chapman Road.

15 Filed JAN 5 - 1922 19 Robert P. Matthews, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3-1922 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 19 22, to Jan 3rd, 19 22,
that I last saw h alive on Jan 3rd, 19 22
and that death occurred, on the date stated above, at 10.15 P. m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

AUTOPSY

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical + Microscopical Examination of Urine

(Signed) William J. Pugh, M. D.

Jan 4th, 19 22 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY	JAN-6-22 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to alcoholism or exposure. May have been due to both.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59990

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Milton Beamer

(a) RESIDENCE. No. 428 North Calvert ST., 4 WARD. (Resident)

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. 4 mos. 13 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Beamer

6 DATE OF BIRTH (month, day, and year) Aug 21, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker & Casket Maker

(h) General nature of industry, business, or establishment in which employed (or employer) Casket Manfacturing

(c) Name of employer National Casket Company

9 BIRTHPLACE (city or town) (State or country) Cavetown Washington Co. Md

PARENTS

10 NAME OF FATHER Henry Beamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cavetown Md

12 MAIDEN NAME OF MOTHER Elizabeth Shanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cavetown Md.

14 Informant (Address) Mercy Hosp. Robert F. Harrison,

15 Filed JAN 5 - 1922 19 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from DEC 21, 1921, to Jan 4, 1922, that I last saw h[illegible] alive on Jan 4, 1922, and that death occurred, on the date stated above, at 12:25 A.M.

The CAUSE OF DEATH* was as follows:

Ruptured Gangrenous appendicitis

(duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Peritonitis & Sepsis

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? 12/21/21

Did an operation precede death? Yes Date of 12/30/21

Was there an autopsy? No

What test confirmed diagnosis? Findings of Operation

(Signed) John L. Elson, M. D.

(Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro-Penna. DATE OF BURIAL Jan-6-1922

20 UNDERTAKER STEWART E. MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59991

CERTIFICATE OF DEATH.

D 59991

47

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1511 E. Hoffman ST.: 8 WARD)

2-FULL NAME Jane Davis

(a) RESIDENCE. NO. 1511 E. Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every fact stated must be full and correct. Any information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Welsey Davis

6 DATE OF BIRTH (month, day, and year) Mar 26 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Robt Merriken

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Susan Dann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Dewitt W. Boyce
(Address) 1511 E. Hoffman St

15 Filed JAN 5 - 1922 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4" 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 1921 to Jan 4 1922

that I last saw h e alive on " " 19 "

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
mammary carcinoma

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) 1 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) L. Lemagnese M. D.

1.5. 1922 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto, Cem. DATE OF BURIAL: 1/7/22

20 UNDERTAKER: Chas. P. Evans & Son ADDRESS 1180 McMechen & Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 59992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

127-007 D 59992

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1430 N. Eden ST.: 9 WARD

2-FULL NAME Michael J. Quirk

(a) RESIDENCE No. 1430 N. E ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Quirk

6 DATE OF BIRTH (month, day, and year) Sept 3- 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57		4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can Capper 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER James Quirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Julia Quirk

(Address) 1430 N. Eden St.

15 JAN 5 - 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4" 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 - 1922 to Jan 4 1922

that I last saw him alive on Jan 3 1921

and that death occurred, on the date stated above, at 5- A. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Lobar Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Benj. D. Harrison M. D.

1/5 - 1922 (Address) 1216 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/6 1922

20 UNDERTAKER Chas. F. Toomey & Son ADDRESS 118 W. Mt Royal Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 59993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 59993

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Romanski

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Romanski

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Martin Romanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed , 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

JAN 5 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1922

17

I HEREBY CERTIFY, That I attended deceased from December 16 1921, to January 4, 1922, that I last saw him alive on January 4, 1922, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 12-17-21

Was there an autopsy? no —

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Brumbock, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	Jany 5th 1922

20 UNDERTAKER Wm. H. Funk

ADDRESS 1835 W. Pratt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59994

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 N. Patterson Park ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A. Rossmann

(a) RESIDENCE NO. 1422 N. Patterson Park ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ...

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles F. Rossmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Augusta M. Theuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Charles F. Rossmann

(Address) 1422 N. Patterson Park ave.

15 Jan 5 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 31st 1922 to Jan 5th 1922

that I last saw h[er] alive on Jan 5th 1922,

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Heart Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path. Dept Report

(Signed) ... M. D.

1922 (Address) 4 W. Mt. Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan. 6th 1922

20 UNDERTAKER: Fredk Lassahn & Son — ADDRESS: Fulton Ave

JAN 5 - 1922

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—E. P. Co.—1000 Bks.

(Covell)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59995

100-007

D 59995

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1625 E. Madison ST.: 7 WARD)

2-FULL NAME Dorothy Covel

(a) RESIDENCE. No. 1625 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Jan. 5. 1919

7 AGE: Years 3; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Robert Covel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Nellie Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Jas. A. Skinner

(Address) 1625 E. Madison St

15 Filed JAN 5 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 . 1921 . to Jan 4 . 1922 .

that I last saw h[illegible] alive on Dec 18, . 1922 .

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Capillary bronchitis (acute)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson . M. D.

1/4 . 1922 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem — DATE OF BURIAL: Jan 6th 1922

20 UNDERTAKER: Jas. A. Skinner — ADDRESS: 1625 E. Madison St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DATE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59996

CERTIFICATE OF DEATH.

D 59996

74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 Dolphin ST. 17 WARD)

2-FULL NAME Annie M. Callahan

(a) RESIDENCE NO. 723 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced: (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: She not know his first Name

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 65 — Months: — Days: — If LESS than 1 day, hrs. or min.: — home no way to find out age

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Alice M. Fechner Penna ave North Ave

15 Filed ..... 19.... Registrar

JAN 5 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921 to Jan 3rd, 1922, that I last saw her alive on Jan 3rd, 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Central Apoplexy

(duration) 2 hours

CONTRIBUTORY (Secondary) Artio Sclerosis. Broncitis (duration) yrs. & mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Kolb, M. D.

(Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Jan 11 1922

20 UNDERTAKER: Wm J Fechner & Son — ADDRESS: North Ave.

SEE REVERSE SIDE. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 59997 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 111

CITY OF BALTIMORE, (No. 510 N Fulton Ave ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gardner Ford

(a) RESIDENCE NO. 510 N Fulton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Ford

6 DATE OF BIRTH (month, day, and year): Dec 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): 006

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Caroline Ford

(Address) 510 N Fulton Ave

15 Filed JAN 5 - 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1921, to Jan 4, 1922

that I last saw him alive on Jan 3rd 1922

and that death occurred, on the date stated above, at 2 00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis about 1 Yr

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 1 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B Bay McClary, M. D.

1/4, 1922 (Address) 406 N. Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 6 1924
20 UNDERTAKER	ADDRESS
H. Turner & Son	Norwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' medical statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. McCleery,
Physician, Mulberry St.
Noncontagious.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59998

CERTIFICATE OF DEATH.

113

D 59998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4508 Reigerstown Road St. 15 WARD)

2-FULL NAME Mary Elizabeth Beall

(a) RESIDENCE NO. 4508 Reigerstown Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 3 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Frederick Beall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore City

12 MAIDEN NAME OF MOTHER: Mary Lindbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt City

14 Informant (Address): Frederick Beall 4508 Reigerston Rd.

15 Filed ....., 19 ..... Registrar

JAN 5 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 6, 1922, that I last saw h[illegible] alive on Jan 6, 1922 and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows: Auto intoxication - (Gastro-Intestinal)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank E Hellard, M. D.

, 19 (Address) 2636 Kate Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 6 1922
20 UNDERTAKER	ADDRESS
Martin Flaherty Sons	807 W North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 59999

CERTIFICATE OF DEATH.

101-001 D 59999

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1022 St Paul ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Grogan

(a) RESIDENCE. No. 1022 St Paul ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3rd 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dont Know

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Joice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Irland

12 MAIDEN NAME OF MOTHER Rebecca Owen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant James L Rogers
(Address) Baltimore Md

15 Filed JAN 5 - 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 4, 1922, that I last saw him alive on Dec 31, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Hepatitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evd

(Signed) Wm H Hammett, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 4 1922
20 UNDERTAKER	ADDRESS
Henry J Rukins Son Co	Eutaw & Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 60000

CERTIFICATE OF DEATH.

D 60000

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 Hanover ST.: W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Connor

(a) RESIDENCE. NO. 600 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Deany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John A. Connor
(Address) 4704 Hamilton Ave

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER. Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 3 1922

17

I HEREBY CERTIFY, That I attended deceased from Jany 1, 1922, to Jany 3, 1922, that I last saw him alive on Jany 2, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchi - Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Signs

(Signed) W. L. Knight, M. D.

, 19 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 7 1922

20 UNDERTAKER Wagner & Holmes ADDRESS 417 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60001

CERTIFICATE OF DEATH.

REGISTERED No. C 24 80

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1741 Light St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James G. Mentis.

(Residence in Baltimore: No 1741 Light St. St.; yrs., 8 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, April 24th. 1921., 1 (Month) (Day) (Year)

7-AGE, ----- yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, George Mentis.

11-BIRTHPLACE OF FATHER (State or Country), Greece.

12-MAIDEN NAME OF MOTHER Tina Magulas.

13-BIRTHPLACE OF MOTHER (State or Country), Greece.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Mentis.(father)

(Address) 1741 Light St.

15- JAN 6 - 1922 (D) ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4th. 1922., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dentition.
Colamboia.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D.
(Coroner.)

Jany. 5..., 1922 (Address) 1917 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery. DATE OF BURIAL, Jan. 6, 1922

20-UNDERTAKER Marquardt & Flynn ADDRESS 422 N. Gay St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60002

CERTIFICATE OF DEATH.

90

D 60002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 642 S. Kenwood ST.; apt WARD)

2-FULL NAME Mary Ratke

(a) RESIDENCE. No. 642 S Kenwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ernest Ratke

6 DATE OF BIRTH (month, day, and year) June 28 1863

7 AGE — Years: 58 — Months: 11 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER Frederick Rausch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Augustina Brenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Ernest Ratke
(Address) 642 S Kenwood Ave

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2 1921, to January 4 1922, that I last saw her alive on January 4 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W Otten, M. D.

(Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cemetery	January 7 1922
20 UNDERTAKER: Robt J Turner Sons	ADDRESS: 1742 N Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60003

CERTIFICATE OF DEATH.

D 60003

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Warner ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Carter

(a) RESIDENCE. NO. 914 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Thomas Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Ann B Watty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Blanche Carter
(Address) 914 Warner St

15 Date: JAN 6 - 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Jan 3, 1922, that I last saw he alive on Jan 3, 1922, and that death occurred, on the date stated above, at 3 am m.

The CAUSE OF DEATH* was as follows: (a) Pneumonia Lobar

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) As Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) C. H. Fiorano, M. D.

, 19 (Address) 1125 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 6 1922
20 UNDERTAKER: John H. Toadvine	ADDRESS 1 W Lexington St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60004

100.001 D 60004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1926 W Pratt (St.) 70 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Laur Jr

(a) RESIDENCE. No. 1926 W. Pratt St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE W

5 Single, ~~Married~~, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 12 - 1921

7 AGE Years — Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER F. J. Laur Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Sophia Flocther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant F. J. Laur Sr.
(Address) 1926 W. Pratt st

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1922, to Jany 4, 1922, that I last saw h~~im~~ alive on Jany 4, 1922, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ~~no~~ Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. J. Rice, M. D.

Jany 4 19 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 1 - 6 - 1922

20 UNDERTAKER: H. C. Browning Son

ADDRESS 517 N Schroeder st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry. and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60005

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Jordan

(a) RESIDENCE. NO. 2107 W. Fayette st. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Jordan

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Dominic Lanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Sherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records (Address) M.C.H.

15 Filed JAN 6 - 1922 16 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1921, to Jan 4, 1922, that I last saw her alive on Jan. 4, 1922, and that death occurred, on the date stated above, at 9.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? T.B. in sputum, X-ray

What test confirmed diagnosis?

(Signed) Francis L. Hedgcock, M. D.

1-5-22. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	192
20 UNDERTAKER	ADDRESS
Geo. A. Tinley	Luther & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60006

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 400 N. Fulton Ave ST.: 20 WARD)

2-FULL NAME Mrs. Martha B. Spedden

(a) RESIDENCE. No. Home for the Aged of the ST., M. E. WARD: Church

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred since 1829. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13 - 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	7	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Duke Bixby Barron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah Ann Beard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Ethel Leverdy (Address) 400 N. Fulton Ave

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH 1922

16 DATE OF DEATH (month, day, and year) Jany 5 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 1921, to Jany 5, 1922 that I last saw h-er alive on January 4, 1922 and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic.

(duration) ✓ yrs. 6 mos. ✓

CONTRIBUTORY (Secondary) Pericarditis

(duration) ✓ yrs. ✓ mos. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) George C. Shannon, M. D.

(Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Jan 6 19 22

20 UNDERTAKER George J Smith ADDRESS 1000 W. Fayette St

N. B.—PLEASE, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 60007

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3641 Edmondson St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie A. Bauhaus

(Residence in Baltimore: No. 2628 Harlem Ave St.: 60 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, May (Month) 6 (Day), 1860 (Year)

7-AGE, 61 yrs. 7 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER, Henry Schaubuch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Doris Kruse

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna C. Bauhaus

(Address) 2628 Harlem ave.

15-

Filed....., 191.... ROBERT R. KRAUTER, Registrar.

JAN 6 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 4 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebritis (Multiple)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) no treatment

(Duration) yrs. mos. ds.

(Signed) J. T. Hemmeter (Coroner.) M. D.

Jan 7, 1922 (Address) 2802 Edmondson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Jan 7, 1922

20-UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60008

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3020 Harford ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. E. Morrison

(a) RESIDENCE. No 3020 Harford ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hugh A. Morrison Sr.

6 DATE OF BIRTH (month, day, and year) Oct. 5-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Samuel B. Spicer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Sophia Leidenstricter
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Kate M. Morrison
(Address) 3020 Harford ave.

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1921, to Jan 5, 1922, that I last saw h[illegible] alive on Jan 4, 1922, and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:
Right Hemaphlegia, Chronic Interstitial Nephritis & Infirmities
3 days of Hemaphlegia 6 day
(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, 2 attacks of Hemaphlegia & Infirmities (duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. R. B. Carman, M. D.
1-5-22
19 (Address) 1701 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Jan 7 1922

20 UNDERTAKER ADDRESS
Wm. C. Clark 927 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60009

CERTIFICATE OF DEATH.

98

D 60009

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3479 Chelmut Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M Smith

(a) RESIDENCE No. 3479 Chelmut Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Susan D Smith

6 DATE OF BIRTH (month, day, and year) Feb 20 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Co Maryland

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah A Ayler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catonsville Maryland

14 Informant Dr Harry Smith

(Address) 3479 Chelmut Ave

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 29, 1921, to Jan 4th, 1922, that I last saw h alive on Jan 4th, 1922, and that death occurred, on the date stated above, at 8.11-00 m.

The CAUSE OF DEATH* was as follows:

Dilitation of Heart, general and senile insufficiency. Profunda

duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clynical Signs

(Signed) R B Norment, M. D.

1.6.1922 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Jan 7 22 19

20 UNDERTAKER A S Marshall ADDRESS 3539 Falls Rd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60010

HEALTH DEPARTMENT—CITY OF BALTIMORE

159 1002

D 60010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Baby Davis

(a) RESIDENCE NO. Church Home & Hosp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 12hrs mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		12hrs	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ..... ✓

(c) Name of employer ..... ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Rubin Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago Ill.

12 MAIDEN NAME OF MOTHER Rose Kirkpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mother (Address) 370 Eastman Balto

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5/1922

17 I HEREBY CERTIFY, That I attended deceased from 1/4 ....., 1922, to 1/5 ....., 1922

that I last saw him alive on 1/5 ....., 1922

and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) 12hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) A. Blackwell M. D.

1922 (Address) Church Home Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 1-6- 1922

20 UNDERTAKER Jack Lewis, 1411

ADDRESS E. Balto.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60011 — 100-001 — D 60011

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. 2 ST.: WARD)

2-FULL NAME Frank Smith

(a) RESIDENCE. NO. 126 S. Castle St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Smith

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address)

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 19 22, to Jan 4th, 19 22, that I last saw h[illegible] alive on Jan 4th 19 22, and that death occurred, on the date stated above, at 5 45 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 126 S Castle St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Boles Andrus, M. D.

1/4, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Rosary — Jan 7 1922

20 UNDERTAKER — ADDRESS

Wm Fiedkowski 1118 Eastern

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60012

D 60012

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3724 Marley ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kelley

(a) RESIDENCE. NO. 3724 Marley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 5. 22

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Flora Uhden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Jos Kelley

(Address) 3724 Marley St

15 Filed JAN 6 - 1922, 19..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1922, to Jan 6, 1922, that I last saw him alive on Jan 5, 1922, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Premature Delivery at 6th Months

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones, M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Jan 6 1922

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Fredk Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60013

D 60013

113

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2500 Mace St. (ST.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sammy Lee Taylor

(a) RESIDENCE. NO. 2500 Mace St. ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) born in Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Foye Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Virginia

12 MAIDEN NAME OF MOTHER Grace Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) x Virginia

14 Informant (Address) Joseph F Taylor 2500 Mace St

15 Filed JAN 6 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 23rd 1922, to Jan 5th 1922, that I last saw him alive on Jan 4th 1922, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enterocolitis

(duration) 1 yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis (duration) 1 yrs. 1 mos. 13 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Carl Hall, M. D.

19 (Address) 1626 E 23 Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 6 1922

20 UNDERTAKER Mrs Robert A Elliott Parkland Pa

ADDRESS 1725

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60014

D 60014

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Morgan

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68 or 58	--	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER William T. Morgan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Washington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed JAN 6 - 1922 H Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1922 to January 4, 1922, that I last saw him alive on January 4, 1922, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

1/5/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Jan 6 1922

20 UNDERTAKER John M Kieber ADDRESS 1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ D 60015

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Vincent Asylum (St.) 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Steinacker

(a) RESIDENCE NO. St Vincent Asylum (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Steinacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary Steinacker (Address) St Vincent Asylum

15 Filed JAN 6 - 1922, 19 H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1921, to January 4, 1922, that I last saw h[illegible] alive on January 4, 1922, and that death occurred, on the date stated above, at 10 Pm.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Edward C Mentzer M. D.

Jan. 6, 1922 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Brae Cem. DATE OF BURIAL Jan. 6 1922

20 UNDERTAKER William J. Tickner & Sons ADDRESS

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60016

CERTIFICATE OF DEATH.

31 D 60016

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 N. Patterson Park Ave. ~~St.~~ 8 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Young Godwin.

(a) RESIDENCE No. 1323 N. Patterson Park Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Aug. 15th. 1889.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	32	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier.

(b) General nature of industry, business, or establishment in which employed (or employer) 686

(c) Name of employer U. S. A.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George P. Godwin.

11 BIRTHPLACE OF FATHER (city or town) Abingdon, (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Young.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Elizabeth Godwin. (mother)

(Address) 1323 N. Patterson Park Ave.

15 Filed JAN 6 - 1922 J. H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany, 5th. 1922.

17 I HEREBY CERTIFY, That I attended deceased from December 11, 1921, to January 5th. 1922.

that I last saw him alive on January 5th. 1922.

and that death occurred, on the date stated above, at 8.00 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? France.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Otto M Reinhardt, M. D.

1/5. 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Gen

DATE OF BURIAL Jan 7 1922

20 UNDERTAKER W. J. Turkheimer

ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 60017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60017

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 N Broadway ST.: 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes M. Horner.

(a) RESIDENCE. NO. 1609 N. Broadway ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of M. F. Horner.

6 DATE OF BIRTH (month, day, and year) Sept 23 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baeto. Md.

PARENTS

10 NAME OF FATHER Chas J. Carman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

12 MAIDEN NAME OF MOTHER Not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mr Millard F Horner (Address) 1609 N. Broadway

15 Filed JAN 6 - 1922 H. H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1921, to Jan 11 1921, that I last saw h[illegible] alive on Jan 7 1921, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Fehling's diabetes

(Signed) M. Fischer, M. D.

, 19 (Address) 29 E. Mt. Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan 7 1922

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N. Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Christian

D 60018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60018

CERTIFICATE OF DEATH.

148

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Helvue Hospital ST., 24 WARD)

2-FULL NAME Christina Jodozinski Berry

(a) RESIDENCE NO. 226 S. Castle ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Berry

6 DATE OF BIRTH (month, day, and year) Sept 1 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	28	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER John Jodozinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER Anna Wanslezyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant George Berry
(Address) 226 S Castle St

15 Filed JAN 6 - 1922 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/4/ .1922, to 1/4/ .1922

that I last saw her alive on 1/4/ .1922

and that death occurred, on the date stated above, at 11:-8 m.

The CAUSE OF DEATH* was as follows:

"Eclampsia."

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? none

What test confirmed diagnosis? —

(Signed) Julius Holzpfenner M. D.

19 (Address) Helvue Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mary Trapp Rd

DATE OF BURIAL: Jan 19 22

20 UNDERTAKER: Wendell Dysel son

ADDRESS: 313 Linn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Four months pregnant
Puerperal eclampsia
due to toxemia of
pregnancy. Acute
nephritis

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60019

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Lohns Lane ST. 72 WARD)

2-FULL NAME Lillie F. Waters

(a) RESIDENCE. NO. 15 Lohns Lane ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 21 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col'd

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Harry Waters

6 DATE OF BIRTH (month, day, and year): Centerville

7 AGE: Years 38; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co.

PARENTS

10 NAME OF FATHER: Andrew Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co.

12 MAIDEN NAME OF MOTHER: Haines Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co

14 Informant: Harry Waters (Address) 15 Lohns Lane

15 Filed JAN 6 - 1922 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 1921, to Jan 4, 1922, that I last saw h... alive on Jan 4, 1922, and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

(Address) Huntingtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvert, Ct. House, Md.

DATE OF BURIAL: Jan 7 1922

20 UNDERTAKER: Edward W Pyle

ADDRESS: 903 Edmonson ave Catonsville

WRITE PLAINLY WITH UNFADING INK—THIS ... be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be ... be properly classified. Exact statement of OCCUPA... CAUSE OF DEATH in plain terms, so that it may be ... of certificates. See Instructions on back of ce... TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 60020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60020

74-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1508 Linden St., 14 WARD)

2-FULL NAME Mary L. Mc Shane

(a) RESIDENCE No. 1508 Linden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 27th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Public School

(c) Name of employer: City

9 BIRTHPLACE (city or town) ..... (State or country) City

PARENTS

10 NAME OF FATHER Lawrence J. Shane

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne E Hara

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ireland

14 Informant Ella Mc Shane

(Address) 1508 Linden ave

15 Filed JAN 6 - 1922 H.H. Wilm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922 to Jan 4th, 1922,

that I last saw her alive on Jan 4, 1922,

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Paralysis, Coma

(Signed) Arthur Webb M. D.

, 19 (Address) 330 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	1-7-1922
20 UNDERTAKER Jas. Inoran	ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60021

CERTIFICATE OF DEATH.

100/00 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 14 N. Rose ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Cox

(a) RESIDENCE No. 14 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Nov 12 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind bis

PARENTS

10 NAME OF FATHER: Patrick Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland Ind. bis

12 MAIDEN NAME OF MOTHER: Eliz Hummel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): bis

14 Informant: Patrick Cox (Address) 14 N. Rose St

15 Filed JAN 6 1922 19 H Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 5, 1922, that I last saw him alive on Jan 4, 1922, and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows: Capillary Bronchitis

NW

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. A. Braun M.D.

1/6, 1922 (Address) 2600 E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 1-7- 1921

20 UNDERTAKER: Jno A. Inman

ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST NOT BE FOLDED. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60022

D 60022

CERTIFICATE OF DEATH.

REGISTERED NO. C 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Pearl ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosario Lasha

(Residence in Baltimore: No. 108 N. Pearl St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, — — 1865
(Month) (Day) (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Sam Lasha

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Antonia Gorbe

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 1011 Eutaw St

15- Robert P. Harrison,

Filed JAN 6 - 1922 191 Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 6, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1922, to Jan 6 1922, that I saw him alive on Jan 6, 1922, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) yr. yrs. mos. ds.

CONTRIBUTORY Diabetic Coma

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry H. Weinberger M. D.

Jan 6, 1922 (Address) 724 N. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Catholic

DATE OF BURIAL, 1/7, 1922

20-UNDERTAKER [illegible]

ADDRESS Fahey Bros 3 & Eight

I.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 60023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60023

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N. East Ave. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha A. Shipley

(a) RESIDENCE NO. 114 N. East Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs 0 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George T. Shipley

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	0	21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Tiepel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dorothea Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jesse B. Shipley

(Address) 114 N. East Ave

15 JAN 8 - 1922 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4. 1922

17 I HEREBY CERTIFY, That I attended deceased from 8-20- ..., 19 21, to 1-4- ..., 19 22.

that I last saw h.. alive on January 4, 19 21.

and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Allen E. Beetham, M. D.

1-4-1921 (Address) 1031 39 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 1/7/1922

20 UNDERTAKER G. Weber & Son

ADDRESS 2503 Edmondson Ave

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, the exact statement of AGE, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60024

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 W. Mulberry St. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine O'Neill

(Residence in Baltimore: No. 930 W. Mulberry St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 23, 1837.
(Month) (Day) (Year)

7-AGE, 90 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John O'Neill

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret McFlynn

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice O'Neill

(Address) 930 W. Mulberry St

15-

Filed Jan 6 - 1922, 191.....

Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 5 -, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 23 - 1922, to Dec 5 - 1922, that I saw h[illegible] alive on Dec. 19[illegible] 192[illegible], and that death occurred, on the date stated above, at 12[illegible] m.

The CAUSE OF DEATH* was as follows:

Senility, Arterio Sclerosis, Cystitis, Acute Nervous Collapse

(Duration) ..... yrs. ..... mos. ..... ds. probably several years

CONTRIBUTORY (Secondary) Exanition about one year

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carlos M. Boots M. D.

Jan 6 -, 1922 (Address) 1107 N. Carrollton Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	1-7-, 1922
20-UNDERTAKER H. C. Flanniken's Son	ADDRESS 517 N. Schroeder St

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 60025

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 001

D 60025

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. Church ST., 7W WARD)

2-FULL NAME Baby Gray

(a) RESIDENCE NO. 16 W. Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5-22.

7 AGE	Years	Months	Days	If LESS than 1 day // hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby, dead

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Rasco

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER Elsie Gray

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Annie Crawford

(Address) 527 Fremont Ave

15 Filed JAN 6 1922, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5 .1922. to Jan 5 .1922.

that I last saw him alive on Jan 5 .1922

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Burns M. D.

1-5. 1922 (Address) 3602 Forest Pk Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn ct DATE OF BURIAL Jan 6 1922

20 UNDERTAKER L. L. Brown & Son ADDRESS 105 W. Lafayette

N.B.—WRITE PLAINLY, WITH INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

D 60026

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

D 60026

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1536 E Clement Av- ST. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Lambka

(Residence in Baltimore: No. 1536 E. Clement Av St. 45 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female.

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (If rite the word): Widowed

6-DATE OF BIRTH: July 14 (Month) (Day), 1842 (Year)

7-AGE: 80 yrs. 5 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Germany.

PARENTS

10-NAME OF FATHER: John Schimmel

11-BIRTHPLACE OF FATHER (State or country): Germany.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennie Wolfram

(Address) 362 Clement Av

15.

Filed ....., 191 .....

Robert P. Harrison, Burial Permit Clerk.

REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 4, (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921, to Jan 4 1922.

that I saw her alive on Jan 3, 1922

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Marasmic Coma

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) ..... yrs. 5 mos. 4 ds.

(Signed) Thos. H. Stevens M. D.

1/5/1922 (Address) 2878 Harford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Jan'y 1922

20-UNDERTAKER: J. A. Frazer & Son

ADDRESS: 703 Hanover

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60027

D 60027

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1522 Hanover St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Marpoe.

(a) RESIDENCE NO. 1522 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Marpoe.

6 DATE OF BIRTH (month, day, and year) Sept 25, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Charles Skuhr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa P.------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles H. Marpoe. (son)

(Address) 923 S. Charles St.

15 Filed JAN 6 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 5th. 1922.

17 I HEREBY CERTIFY, That I attended deceased from December 17, 1921. to January 5th. 1922.

that I last saw her alive on January 4th. 1922.

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. 0 mos ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Otto M. Reinhardt, M. D.

1/5. 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Jany 7 1922

20 UNDERTAKER J. Frew McCully ADDRESS 1302 Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION on back of certificates. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60028 ✓ D 60028

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH
CITY OF BALTIMORE: No. 633 Cumberland St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A. Parks

(Residence in Baltimore: No. 633 Cumberland St. St.; ..... yrs., ... mos. ..... ds.)

AGE should be stated EXACTLY. FRACTIONS OF A YEAR properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. A CERTIFICATE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F | 4-COLOR OR RACE, W | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 1 (Month) 27 (Day), 1851. (Year)

7-AGE, 70 yrs. 11 mos. 9 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, Jno. Parks

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Mongarrity

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Emma McCloskland
(Address) 633 Cumberland St.

15- Filed JAN 6 1922, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 6 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27 1921, to 1. 6 1922,
that I saw her alive on 1. 6 1922,
and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. 2 Weeks ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (Duration) ..... yrs. ..... mos. 4 ..... ds.

(Signed) Leonard Dunlington M. D.

1. 6, 1922 (Address) 102 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cem | DATE OF BURIAL, 1/9, 1922

20-UNDERTAKER J. Frew McCarthy | ADDRESS 130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60029

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 Jackson ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rebstock

(a) RESIDENCE. NO. 1524 Jackson ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrick Rebstock

6 DATE OF BIRTH (month, day, and year) Dec 8, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles Rebstock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Dibble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. G. Rebstock 1524 Jackson St.

15 Filed ..... 19.. Registrar

AN6 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to Jan 5, 1922, that I last saw h.. alive on Jan 5, 1922, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ephemeral

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. F. Campbell, M. D.

1/6 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	1/9 1922
20 UNDERTAKER	ADDRESS
J. Fenw McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S name should be stated EXACTLY. PHYSICIAN'S address and signature should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased is very important. See instructions on CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Mike Antico)

D 60030

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 60030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital 3rd WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mike antico Antico

(Residence in Baltimore: No. 240 Aisemore St St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ? (Month) ? (Day) 1887 (Year)

7-AGE, 34 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —— OHC

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Nicolola Antico

11-BIRTHPLACE OF FATHER (State or Country), ? Italy

12-MAIDEN NAME OF MOTHER Palmarosa Diemilo

13-BIRTHPLACE OF MOTHER (State or Country), ? Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicolola Antico

(Address) 340 Albemarle

15-

JAN 6 1922, 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1921 to Jun 5 1921 that I saw him alive on Jun 5 1921 and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

(Duration) ..... yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) to Pneumia

(Duration) — yrs. — mos. 2 ds.

(Signed) H. C. Warlick M. D.

Jan 6, 1921 (Address) Franklin Sq. Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. 7 ds.

Where was disease contracted, if not at place of death? 240 Albemarle St

Former or usual residence 240 Albemarle St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Vincents Cem	January 7, 1921
20-UNDERTAKER	**ADDRESS**
Wendell Dyffel & Son	37 S Inn

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY. PENCIL MAY BE USED. AGE should be stated EXACTLY. PHYSICIAN'S ... may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Blks.

D 60031

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 60031

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3126 Walbrook ave ST., 70 WARD)

2-FULL NAME Regina Anderson

(a) RESIDENCE No. B 156 Walbrook ave ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. — mos. 10 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

N. B.—WHITE PLAINLY, and all the information should be carefully supplied. AGE should be stated EXACTLY. Literal CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J. Anderson

6 DATE OF BIRTH (month, day, and year) Dec 26 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	65	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Grobe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Bedev

12 MAIDEN NAME OF MOTHER Stella Festerling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Stella Jester (Address) 3126 Walbrook ave

15 Filed JAN 6 - 1922, 19..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Jan 5, 1922,

that I last saw h-alive on Jan 4, 1922,

and that death occurred, on the date stated above, at 11 30 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) Hrs Days ds.

CONTRIBUTORY (Secondary) Acute Dilatation

Salmonella Infection yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert P Grubbs M. D.

Jan 6 1922 (Address) 215 Walbrook ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Jan 9 1922

20 UNDERTAKER F. B. Heppert — ADDRESS 2236 Fred'k Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60032 D 60032

CERTIFICATE OF DEATH.

Sarah A. Thalheimer 49

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 N. DURHAM ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Thalheimer

(Residence in Baltimore: No. 1520 N DURHAM St.; Was Known ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	Married

6-DATE OF BIRTH, Aug 21, 1880
(Month) (Day) (Year)

7-AGE, 41 yrs. 4 mos. 16 da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Farr

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Magdalina Zeller

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Philip Thalheimer

(Address) 1520 N. Durham St.

15-

Filed ... 191... Robert F. Harrison, Registrar.

JAN 7 - 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from JAN 1 1912, to JAN 6 1922 191..., that I saw her alive on JAN 6 1922 191..., and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Cancer of bladder

(Duration) 1 yrs. 4 mos. 4 ds.

(Signed) O. H. Duker M. D.

JAN 6 1922, 191... (Address) 928 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Jan 9, 1922

20-UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

I.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60033

D 60033

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 133 Collins Ave. ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Lee Brandenburg

(a) RESIDENCE. No. 133 Collins Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Lee Brandenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md

12 MAIDEN NAME OF MOTHER Florence Sattel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Leo Brandenburg
(Address) 133 Collins Ave

15 Filed JAN 7 1922 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 15, 1921, to Jan 5, 1922,

that I last saw h[illegible] alive on ..... 19 2[illegible]

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

(Chronic Intestinal Indigestion

Rickets

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Convulsion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Edw. P. Cochran, M. D.

1/6, 19 22 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 7 1922

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. North Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Full name of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 7 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard Jones St. ST.; 9 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Doyle

(a) RESIDENCE. No. 635 E 30th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 19 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 31 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	19	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Danaly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Office Files.
(Address)

15 Filed JAN 4 1922 19 Robert P. Harrison, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/22 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to Jan 6, 1922, that I last saw her alive on Jan 6, 1922, and that death occurred, on the date stated above, at 6.15 A.m.

The CAUSE OF DEATH* was as follows:

Malignant Empyema & Septicaemia

DVH

(duration) 2 yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 635 E. 30th St.

Did an operation precede death? Yes Date of 1/4/22

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Cyrus J. Hoke, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 7 1922

20 UNDERTAKER Chenowith & Son ADDRESS Chestnut Ave

N. B.—The information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60035

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3614 Railroad ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eveline A Breswell

(a) RESIDENCE. No. 3614 Railroad ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L Breswell

6 DATE OF BIRTH (month, day, and year) May 9 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER James Lisbear

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Margaret Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant John L Breswell

(Address)

15 Filed Jan 9 1922 Robert P. Harrison Registrar

Burial Permit Clerk

N 7 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1922, to Jan 6th, 1922,

that I last saw h sr alive on Jan 5th, 1922,

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilation

O.V.Ed

CONTRIBUTORY (Secondary) High blood pressure (duration) 1 yrs. mos. ds.

Chronic myocarditis

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) B. F. Elliott, M. D.

6. 1922 (Address) N. 27 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Jan 9 1922

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage
Phy. only attended 2 days

Spec.—1-10-21—M&T—1500 Bks.

D. 60036 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60036

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Presstman Road WARD 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn L Mc Geach

(a) RESIDENCE NO. 2332 Presstman Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 16/21

7 AGE: Years 10 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): ddo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frank N Mc Geach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lenore Nuckles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Frank N Mc Geach 2332 Presstman Rd

15 Filed JAN 7-1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Jan 5, 1921.

That I last saw her alive on Jan 5, 1921,

and that death occurred, on the date stated above, at 1 00 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Thrombitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Louis Flosser, M. D.

(Address) 3405 Fenwick a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Interment — DATE OF BURIAL: Jan 7 1922

20 UNDERTAKER: William Lockard — ADDRESS: 502 E Monta

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Professional information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 60037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60037

CERTIFICATE OF DEATH.

REGISTERED NO. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3905 Towanda ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James George

(Residence in Baltimore: No. 3905 Towanda Ave St.: 15 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) 17 (Day), 1921 (Year)

7-AGE, yrs.. 8 mos.. 19 ds.

If LESS than 1 day. hrs. or mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, Jacob George

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Eulalia Jooley

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob George

(Address) 3905 Towanda Ave

15-

Filed JAN 7 1922, 191

Robert F. Harrison
Chief Permit Clerk.
Registrar.

S.B.—Every item of information must be given as nearly as possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 6 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 5 1921, to Jan 6 1921, that I saw him alive on Jan 6 1921, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) yrs. 2 mos. ds.

(Signed) C H Bueter M. D.

1.6., 1922 (Address) 1N W Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL Jan 7, 1922

20-UNDERTAKER H S Marshall ADDRESS 3539 Falls Rd

D 60038

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60038

CERTIFICATE OF DEATH.

REGISTERED No. C 129

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 124 n Curley St. Ward) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Schroder

(Residence in Baltimore: No. 124 n Curley St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Nov 20, 1865
(Month) (Day) (Year)

7-AGE, 56 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm F Schroder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Marie Lamp

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marie K. Schroeder
(Address) 124 N Curley St

15-
Filed ....., 191.....
Registrar.

Robert P. Harrison

JAN 7 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:*
Chronic Cardiac Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ?
(Duration) ....yrs. ....mos. ....ds.

(Signed) W H Smith M. D.
(Coroner)
1-6-22, 1921 (Address) 918 Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Jan 7, 1921.

20-UNDERTAKER J Kenney & Co

ADDRESS 1005 Eutaw St

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60039

CERTIFICATE OF DEATH.

31 D 60039

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 E. Eager ST. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Callahan

(a) RESIDENCE. NO. 827 E. Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Callahan

6 DATE OF BIRTH (month, day, and year) Sept 5, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John Callahan 827 E. Eager St

15 Filed JAN 7-1922, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5' 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to Jan 5, 1922, that I last saw h[illegible] alive on Jan 5, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Nephritis, Toxic

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted, if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

Jan. 19 22 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 7 1922
20 UNDERTAKER	ADDRESS
H. C. Rudefeld	9 E Preston

I.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHRASES such as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. only attended 1 day. Heard some report of probable tuberculosis. Patient reported in Nursing Division from Phipps as positive tbc. 14½ Patient up at sanatorium.

Sam Nesler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60040

CERTIFICATE OF DEATH.

170 D 60040

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Druid Hill Park Ave ST. OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sam Nesler

(Residence in Baltimore: No. 305 - S. 14th St.: 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ....., 1881 (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Puncher in Mill
(b) General nature of industry, business, or establishment in which employed (or employer)..... Shed at Sparrows Point

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Dont Know.

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Dont Know.

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ramon Shutska

(Address) 305 S. Fourteenth St.

15-

Filed ....., 191.....

Robert F. Harrison,
Burial Permit Clerk.
Registrar.

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

7-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot Wound through Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Monroe M. D.
(Coroner)

Jan 6 1922 (Address) 722 Poplar

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Jan 7th, 1922

20-UNDERTAKER Lilly + Zeiler

ADDRESS 403 S. Wolfe

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60041

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Riverside ave. ST.: 24 WARD)

2-FULL NAME Joseph Edward McKay.

(a) RESIDENCE. NO. 1219 Riverside ave ST. 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of ~~WIFE~~ of Caroline Brady

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Benj. McKay

11 BIRTHPLACE OF FATHER (city or town) St Marys Co Md (State or country)

12 MAIDEN NAME OF MOTHER Susan Bennett

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co Md (State or country)

14 Informant Caroline McKay (Address) 1219 Riverside Ave

15 Filed JAN 7 1922 . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5/22 19

17 I HEREBY CERTIFY, That I attended deceased from 6/1/21, 19, to 1/5/22, 19, that I last saw him alive on 1/5/22, 19, and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Myocarditis

(duration) 6 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? Physical Examination

What test confirmed diagnosis?

(Signed) J. Edward Burns, M. D.

1/6, 1922 (Address) 1430 Riverside ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Co Md	1/8 19 22
20 UNDERTAKER	ADDRESS
J. F. Lahey & Sons	1318 Eutaw St

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Thomas Sperando)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60042

CERTIFICATE OF DEATH.

D 60042

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (Street) 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Sperando

(a) RESIDENCE. No. 829 N. Central Ave (Street) WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Sperando

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Lamartina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Anthony Sperando
(Address) 829- N. Central Ave.

15 Filed JAN 7 - 1922, 19 [illegible] Registrar

[illegible] Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922, to Jan 7, 1922, that I last saw h[illegible] live on Jan 6, 1922, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. MacGowan, M. D.

1/7/22 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cems

DATE OF BURIAL [illegible] 19

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford ave

Should be carefully supplied. All information should be carefully supplied. Exact statement of OCCUPATION may be properly classified, so that it may be properly classified. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60043

CERTIFICATE OF DEATH.

REGISTERED No. C 73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2624 N. Calvert ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta MacLea

(Residence in Baltimore: No. 2624 N. Calvert St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	White	Married

6-DATE OF BIRTH, Jan (Month) 31 (Day), 1869 (Year)

7-AGE, 52 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Fred Peters

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lena Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. MacLea

(Address) 3624 Calvert St

15-

Filed ..... 191.....

Registrar.

JAN 7-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 5 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1921, to Jan 5 1922, that I saw her alive on Jan 5 1922, and that death occurred, on the date stated above, at 11.57 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Progressive Muscular Atrophy,

(Duration) 3 yrs. ....mos. ....ds.

(Signed) Geo M Lea M. D.

Jan 6, 1922 (Address) 30 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loraine	Jan 9, 1922
20-UNDERTAKER Fickler Funeral Home	ADDRESS 1734 Eager

N. B.—Every item of information should be given as full as possible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60044

D 60044

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 E. Oliver St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan A Lentz

(a) RESIDENCE. NO. 1618 E Oliver ST., WARD.
(Usual place of abode) Dallastown
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Jan 1 1847

7 AGE Years 74 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home mkr

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greencastle Pa

PARENTS

10 NAME OF FATHER John S Zeigler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Cauble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Nellie J Lentz

(Address) 1618 E. Oliver St

15 Filed JAN 7 1922, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1922

17 I HEREBY CERTIFY, That I attended deceased from December 31, 1921, to Jan 6, 1922; that I last saw h[illegible] alive on Jan 6, 1922, and that death occurred, on the date stated above, at 8 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency,

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym. Symptoms

(Signed) A. David Zeigler, M. D.

, 19 (Address) 1736 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greencastle Pa	Jany 9 1922

20 UNDERTAKER Rupp & Zimmerman Bros ADDRESS 1742

...mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60045

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 29 D 60045

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 611½ Central Ave St. 7 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frances Williams

(Residence in Baltimore: No. 611 Central Ave St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: dont Known, 1855 (Month) (Day) (Year)

7 AGE: 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Williams

(Address) 611 N Central Ave

15 Robert P. Harrison, 191

JAN 7 - 1922 Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 5th, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 10th, 1921, to January 5th 1922 that I saw h alive on January 4th, 1922 and that death occurred, on the date stated above, at 1:30 p m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Contributory (SECONDARY) Exhaustion (Duration) 1 yrs. mos. ds.

(Duration) 2 yrs. mos. 7 ds.

(Signed) J. E. Tilly M. D.

Jan 5th, 1922 (Address) 709 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cemetary DATE OF BURIAL: Jan 8 1922

20 UNDERTAKER: Clement Hall ADDRESS: 709 Hillen St

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Voda) ✓ 001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60046

CERTIFICATE OF DEATH. 101

D 60046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen. Hospital ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Voda

(a) RESIDENCE. No. 2119 Bank St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1919

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Akron Ohio

PARENTS

10 NAME OF FATHER Walter Voda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Pauline Tamaszkiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Peter Jagodzinski
(Address) 2119 Bank St.

15 Filed JAN 6 1922 19 Robert P. Harrigan, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4. 1922, to Jan 6. 1922, that I last saw him alive on Jan. 6. 1922, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bilateral) (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cellulitis of left thigh (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Jan 4, 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Pokorny, M. D.

19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 9 1922

20 UNDERTAKER John M Weber ADDRESS 1803 Bank st

mation should be carefully supplied. Exact statement of OCCUPA
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of cellulitis unknown. Lobar pneumonia secondary.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60047

CERTIFICATE OF DEATH.

X159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 N Balto St. ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarissa Davis

(a) RESIDENCE. NO. 1102 N Balto St. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 1921

7 AGE — Years: — Months: 4 Days: 9. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ———

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): New York City

PARENTS

10 NAME OF FATHER: Fred H. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York City

12 MAIDEN NAME OF MOTHER: Jennie Tyser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mobile Ala

14 Informant: Fred H. Davis

(Address) 1102 N Balto St

15 Filed Robert F. Harrison, Registrar

N 7 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922, to Jan 6, 1922, that I last saw her alive on Jan 6, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Pyloric Stenosis

Gastric Indigestion

(duration) yrs. 4 mos. 9 ds.

CONTRIBUTORY (Secondary) Accidents

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? ——— Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Edw J Coleman, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet

DATE OF BURIAL: Jan 7 1922

20 UNDERTAKER: Geo J. Smith & Son N Fayette

ADDRESS

mation should be carefully supplied. ... it may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it ma... TION is very important. See instructions on ba...

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60048

CERTIFICATE OF DEATH.

44

D 60048

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Friendsbury ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isreal Kushner

(a) RESIDENCE NO. 1608 Friendsbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beckie Kushner

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Varnisher 051

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Kushner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1411 E. Balto St.

15 Filed JAN 7 1922, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 19 21, to Jan 3, 19 22, that I last saw h[illegible] alive on Jan 3, 19 22, and that death occurred, on the date stated above, at 5.05 A.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

3 / 6 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of March 1921

Was there an autopsy? No.

What test confirmed diagnosis? Exploratory operation

(Signed) Wesley A. Bonsett M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem & | DATE OF BURIAL Jan 8 19 22

20 UNDERTAKER Jack Lewis | ADDRESS 1411 E Balto

mation should be carefully supplied. Avoid ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60049

CERTIFICATE OF DEATH.

10 D 60049

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2328 Jefferson St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Levenson

(a) RESIDENCE NO. 2328 Jefferson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 6 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	4	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Levenson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Lilly Blichman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Louis Levenson
(Address) 2328 Jefferson

15 Filed ..... 19 ..... Registrar

JAN 7 1922 Robert F. Hardisty
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922, to Jan 6, 1922,

that I last saw h[illegible] alive on Jan 6 1922,

and that death occurred, on the date stated above, at 8 10 P. m.

The CAUSE OF DEATH* was as follows:

Asphixia (over)

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary) Meyer Ephraim

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Meyer Ephraim M. D.

19 (Address) 1904 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodph Road — DATE OF BURIAL Jan 7 1922

20 UNDERTAKER Jack Lewis — ADDRESS 1410 E Balt

mation should be carefully supplied. Age should be given in years, months and days. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by a layman. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1527/18 D 60050

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60050

CERTIFICATE OF DEATH.

5 146

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.: 5 (Ward)

2-FULL NAME Ethel Barber

(a) RESIDENCE. No. 1126 Gray ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Barber

6 DATE OF BIRTH (month, day, and year) 2-18-1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Rosa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant
(Address)

15 Filed JAN 7 1922, 19 Robert F. Harrison
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-19, 1921, to 1-6, 1922, that I last saw h-er alive on 1-6, 1922, and that death occurred, on the date stated above, at 6 20 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peri-nephritic abscess.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Donald Pa	Jan 7 1922

20 UNDERTAKER John W Henderson

ADDRESS 1502 Monument

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

C0051

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 60051

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2769 almeda ave St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph P Higgs

(Residence in Baltimore: No. 2769 almeda ave St.; .....yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	Infant

6-DATE OF BIRTH, January 2, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 4½ ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) 2769 almeda Baltimore Md

PARENTS.

10-NAME OF FATHER Joseph P Higgs

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Annie J Fahey

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Higgs

(Address) 2769 Alameda Ave

15- JAN 1922 Robert P. Harrison,

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 2 1922, to January 7 1922, that I saw h— alive on January 7 1922, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth
at about 7 months

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Heart Weakness

(Duration) ....yrs. ....mos. 4 ds.

(Signed) H Dan'l Wathen M. D.

January 7, 191.. (Address) 1616 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem.	Jan. 7..., 1922
20-UNDERTAKER Lilly & Zeile	ADDRESS 403 S Broadway

N.B.—Every item of information must be given if possible. Fill in answers so that it may be properly classified. Print plainly. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D60052 HEALTH DEPARTMENT—CITY OF BALTIMORE D60052

CERTIFICATE OF DEATH. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4202 Gwynn Oak Ave St.. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas. F. Smith

(a) RESIDENCE. No. 4202 Gwynn Oak Ave St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ruth A Smith

6 DATE OF BIRTH (month, day, and year) Aug 6, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5		

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mt Vernon Cotton Duck Mill

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Ruth A Smith

(Address) 4202 Gwynn Oak Ave

15 Filed JAN 8 — 1922 19

Burial Permit Clerk.

ROBERT R. KRAUTER.

Registrar

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19 25, to January 6 19 22, that I last saw h alive on January 6 19 22, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 6 yrs. mos. da.

CONTRIBUTORY (Secondary) Nephritic tyxemia

(duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary tests

(Signed) Frank M Smith M. D.

Jan 6, 1922 (Address) 4435 Mary Land Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Jan 9 '22

20 UNDERTAKER W S Marshall ADDRESS 3539 Fall Rd

Spec. 6-9-10 H. P. Co. 1000 Blks.

D 60053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60053

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 834 (Sharp) ST.: 27 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola B. Hill

(a) RESIDENCE. NO. 834 Sharp ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 11 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER James T. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) James T. Hill 834 Sharp St

15 Filed JAN 8 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to Jan 6 1922, that I last saw h[illegible] alive on Jan 6 1921, and that death occurred, on the date stated above, at 2 55 a m.

The CAUSE OF DEATH* was as follows:

* Tuberculosis

OVER

(duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagn. Characteristic Symptoms

(Signed) J. T. Fisher, M. D.

Jan 7 1922 Address) 1125 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 9 1922
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Full statement of cause of death is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer, Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60054

D 60054

CERTIFICATE OF DEATH.

118

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Spence

(a) RESIDENCE. NO. 936 East Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Spence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary B Quirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mercy Hospital Records

(Address)

15 Filed JAN 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1922.

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1922, to Jan 7, 1922

that I last saw him alive on Jan 7, 1922,

and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Gangrenous Intestines & Peritonitis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Jan 5, 22

Was there an autopsy? —

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) John J Ensor, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Jan 10 22
20 UNDERTAKER	ADDRESS
Orth & Sons	1700 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of death TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60055

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tom Parker

(a) RESIDENCE. No. 413 Annapolis Road ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude

6 DATE OF BIRTH (month, day, and year) Nov 5 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabin Helper 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London England

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) London England

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London England

14 Informant
(Address)

15 Filed . . 19 Registrar

JAN 8 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1922

17 I HEREBY CERTIFY, That I attended deceased from 10-18 1921 to 1-7 1922

that I last saw him alive on 1-7 1922.

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of urethra
Extravasation of urine & abscess formation (10-18-21 ?)
Pyelitis, bilateral ?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? yes Date of 10-8-21 11-23-21

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy - Histological Section of material taken at operation

(Signed) Julian D. Hart, M. D.

, 19 (Address) Johns Hopkins Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	1-9 1922
20 UNDERTAKER William Cook	ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1808 N. Caroline ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Proctor

(a) RESIDENCE. No. 1808 N. Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susanna Proctor

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years: about 84; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Plasterer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Robert H. Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Mrs Della Royston
(Address): 1909 N Caroline St

15 Filed JAN 8 - 1922, 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922, to Jan 7, 1922, that I last saw him alive on Jan 7, 1922, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Sandeman, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 1-10 1922

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease TION is very important. See instructions on back of certificates.

D 60057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68 D 60057

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md General Hosp. ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Shelton

(Residence in Baltimore: No. 2555 W. Fairmount Ave ST.: yrs., 5 mos. 11 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July 26, 1896 (Month) (Day) (Year)

7-AGE, 25 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): D&B

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Wm A Shelton

11-BIRTHPLACE OF FATHER (State or Country), Ill.

12-MAIDEN NAME OF MOTHER, Margaret A Green

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret A Shelton

(Address) 2555 W Fairmount Ave

15- JAN 8 - 1922 ROBERT R. KRAUTER, Registrar.

Filed....., 191.....

Burial Permit Clerk.

Ed Hennessy 2502 Edmondson Ave

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry) find that said deceased came to Death on the date stated above.

The CAUSE OF DEATH* was as follows:

Cocaine poisoning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) accidental (self administered)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner)

Jan 8, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery. DATE OF BURIAL, Jan 9, 1922

20-UNDERTAKER Wm Cook ADDRESS 502 E North Ave

Important. See instructions on back of certificate.

Addict & look outdoor

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for maliguant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 60058

CERTIFICATE OF DEATH.

129 D 60058

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Durham ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lewis.

(a) RESIDENCE NO. 1621 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman 079

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Stephen Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary E Lewis (Address) 1621 Hatteras St

15 Filed JAN 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 7 1922

17 I HEREBY CERTIFY, That I attended deceased from December 4th 1921 to January 7th 1922 that I last saw him alive on January 6th 1922 and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) R C Silby M. D.

(Address) 1621 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem DATE OF BURIAL Jan 9. 1922

20 UNDERTAKER Wm Cook ADDRESS [redacted]

I hereby certify that it may be properly classified. Exact statement of cause of death in plain terms, so that information should be given. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60059

CERTIFICATE OF DEATH.

90 D 60059

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Clifton Place ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Gulser

(Residence in Baltimore: No. 1602 Clifton Place. St.; 15 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, October, 1, 1841
(Month) (Day) (Year)

7-AGE, 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Caroline Co., Md.

PARENTS.

10-NAME OF FATHER, Peter Collison

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Caroline Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. A. Williams

(Address) 1602 Clifton Place

15-

Filed JAN 8 1922, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 5, 1921, to January 6, 1922, that I saw her alive on January 3, 1922, and that death occurred, on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis & Valvular Heart Disease.

(Duration) ?yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Helen L. Singewald M. D.

1/7/, 1922 (Address) 1613 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Centerville Md. DATE OF BURIAL, 1-9, 1922

20-UNDERTAKER William Cook ADDRESS 502 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every certificate is important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60060

CERTIFICATE OF DEATH.

X 49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) ST.: (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Painter

(a) RESIDENCE. NO. 761 W 3rd St. Williamsport Pa. WARD. Williamsport, Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Emma Painter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Jacob Chandler Painter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth S. McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address)

15 Filed JAN 8 - 1922 ROBERT R. KRAUTER Clerk.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 7, 1922, that I last saw h alive on Jan 7, 1922, and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Williamsport. Pa

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S B Mac Crendy, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Williamsport. Pa.	1/8/1922

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette Ave.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60061 — 101 — D 60061

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1021 Argyle Ave. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Garfield Hooper

(Residence in Baltimore: No. 1021 Argyle Ave. St. 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1882 (Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Balto Co. Md

PARENTS.

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Johnson

(Address) 1021 Argyle Ave

15- JAN 8 - 1922 ROBERT P. BRAUER, Filed ....., 191..... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1922, to Jan 5 1922, that I saw h[illegible] alive on Jan 4 1922, and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

1st Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) John Ottenwart M. D.

Jan 6 1922 (Address) 904 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Jan 9, 1922

20-UNDERTAKER David Carter — ADDRESS 96 Cam

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60062

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

179

D 60062

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1129 Park Ave. ST.: — WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Harriett Jones

(Residence in Baltimore: No. 1129 Park ave ST.: 42 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widow

6 DATE OF BIRTH: ..... (Month) ..... (Day) 1871 (Year)

7 AGE: 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): for h

9 BIRTHPLACE (State or country): Va

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E J Jones

(Address) 1134 Park ave

15 Filed JAN 8 - 1922, 191 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 4, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922, to Jan 4 1922
that I saw her alive on Jan 4, 1922
and that death occurred, on the date stated above, at 9 p.m.
The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) 20 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Syphilis (Chronic)

(Duration) 1 yrs. ..... mos. 6 ds.

(Signed) Wm Gilchrist Dunn, M. D.

1/8, 1922 (Address) 1223 Park ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cem — DATE OF BURIAL: Jan 8th, 1922

20 UNDERTAKER: David Taylor — ADDRESS: 116 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. ABBREVIATIONS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60063 ✓ D 60063

CERTIFICATE OF DEATH.

96

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 139 N Exeter ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zlotta Waldermen

(a) RESIDENCE. No. 139 N Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Unborn

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Mehlman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Paul Waldeman (Address) 139 N Exeter St

15 Filed JAN 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1922

17 I HEREBY CERTIFY, That I attended deceased from December, 1921, to Jan 7, 1922, that I last saw h— alive on Jan 7, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - myocarditis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): oedema of lungs

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Fred Lentz, M. D.

Jan 8, 1922 Address) 1040 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Jan 9 1922
20 UNDERTAKER: May Jenkins	ADDRESS 1041 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60064 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60064

CERTIFICATE OF DEATH.

74-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 W. Lanvale ST.; 17 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Gaddis

(Residence in Baltimore: No. 545 W. Lanvale St.; 80 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown ....., 1840
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Leonardtown Md

PARENTS.

10-NAME OF FATHER, Samuel Roberts

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sophia Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Nelson

(Address) 547 W Lanvale Street

15- JAN 8 - 1922 ROBERT R. KRAUTER,
Filed....., 191..... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2 1922, to Jan 5 1922, that I saw h[illegible] alive on Jan 5 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Coma

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W. J. Carr M. D.

Jan 7, 1922 (Address) 515 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Jan 8, 1922

20-UNDERTAKER Samuel J. Hemler — ADDRESS 578 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60065

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Hanover ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Jenkins

(a) RESIDENCE. No. 1738 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Julia A. Jenkins

6 DATE OF BIRTH (month, day, and year) Feb 25 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Iron Worker.

(b) General nature of industry, business, or establishment in which employed (or employer) Kern & Hagerty Co.

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. N Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Margaret Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Julia A. Jenkins (wife)
(Address) 1738 Hanover St

15 Filed JAN -8 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Jan 6, 1922 that I last saw h~~im~~ alive on Jan 6, 1922 and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Uremia.

CONTRIBUTORY (Secondary) Chronic Bright's disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ~~No~~ Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Kinsel M. D.

1/7, 1922 (Address) 6 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	1-10 1922
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60066

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 - 001
D 60066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 706 Harvey ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis J. O'Brien

(a) RESIDENCE. No. 706 Harvey ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Annie O'Brien.

6 DATE OF BIRTH (month, day, and year) Oct 22 1881

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
40	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer Cahill & Co

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Edw O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie O'Brien
(Address) 706 Harvey St.

15 (Filed) 1-8 19 ROBT. R. KRAMER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2d 1922 to July 8th 1922 that I last saw him alive on July 7 1922 and that death occurred, on the date stated above, at * 4.45 A m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~go~~

Did an operation precede death? No Date of —

Was there an autopsy? ~~Yes~~

What test confirmed diagnosis? ~~Clinical~~

(Signed) A L DeRenzo M. D.

19 (Address) 134 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	1-11 1922
20 UNDERTAKER E & B Hahn	ADDRESS 115 E Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60067

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

101 D 60067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 E. 28th St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy S. Alderman

(a) RESIDENCE NO. 1736 E 28th. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced (HUSBAND) of (or) ~~WIFE of~~ Frances E. Alderman

6 DATE OF BIRTH (month, day, and year) Jan. 28. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper. 008

(b) General nature of industry, business, or establishment in which employed (or employer) Balls Bargain House.

(c) Name of employer Jacob. Epstein.

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Wm Alderman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Guenn Lester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Frances E. Alderman

(Address) 1736 E 28 St

15 Filed JAN 6 1922, 19 Registrar

ROBERT R. KRAUTER, Clerk Circuit Court

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1922, to Jan. 6, 1922, that I last saw him alive on Jan 6, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Thos. Fa Stevens, M. D.

1/6, 1922 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 1-9 1922

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gosnell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60068

CERTIFICATE OF DEATH.

129 D 60068

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 Penna. Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gosnell

(a) RESIDENCE. NO. 2010 Penna ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	~~Widow~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20-1853

7 AGE 68 Years 1 Months 16 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benj Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr George Gosnell
(Address) 1417 Edmondson Ave

15 Filed JAN 8 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6 — 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/20, 1921, to 1/6 —, 1922, that I last saw h(er) alive on 1/6 —, 1922 and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH was as follows:

Chr. Nephritis

Uremia Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj R Butler, M. D.

, 19 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fred Auburn Cem	Jan 8 1922

20 UNDERTAKER ADDRESS

George H. Holland 1631 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60069

CERTIFICATE OF DEATH.

D 60069

93

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 N Bradford St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sandra

(a) RESIDENCE. No. 708 N Bradford St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Sandra

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Railroad Flag

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Sandra

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Mary Sandra 708 N Bradford St

15 Filed JAN 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 5, 1922

that I last saw him alive on Jan 4, 1922

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Agitans Paralysis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Runyon M. D.

1-7, 1922 (Address) 800 N Patt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 9 1921
20 UNDERTAKER	ADDRESS
Frank Enoch & Son	906 Forbleud

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 60070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60070

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N Bond ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Tilsch

(a) RESIDENCE. No. 5 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Vincent Tilsch

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant M. Tilsch
(Address) 5 N Bond St

15 Filed JAN 8 1922 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 21, 1921, to Jan 3, 1922, that I last saw h er alive on Jan 3, 1922, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 10 yrs. + mos. ds.

CONTRIBUTORY (Secondary) myocardial failure

(duration) 2 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) Edward Novak, M. D.

, 19 (Address) 821 N. Patterson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Jan 9 1922
20 UNDERTAKER	ADDRESS
Emil Groschner	916 Eastland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be filled. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60071

CERTIFICATE OF DEATH.

89

D 60071

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 33 Cedar St, Centre Bay ST., 25 WARD)

2-FULL NAME Annie Yelenik

(a) RESIDENCE NO. 33 Cedar St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of George Yelenik

6 DATE OF BIRTH (month, day, and year) July 26, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joe Eakly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Joseph Yelenik
(Address) 33 Cedar St.

15 Filed JAN 8 1922, 19.. Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922, to Jan 6, 1922, that I last saw h.. alive on Jan 6, 1922, and that death occurred, on the date stated above, at 10:40 p. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos ½ hour ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of X

Was there an autopsy? no

What (est confirmed) diagnosis? —

(Signed) Geo. T. Dawson, M. D.

1/6, 1922 (Address) 211 Church St. Centre Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C.C. Lot — DATE OF BURIAL Jan 10 1922

20 UNDERTAKER Frank Isaac & Son — ADDRESS 1906 Bob Lane

mation should be entered. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Koetting

HEALTH DEPARTMENT—CITY OF BALTIMORE

60072

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH Rosedale Hamilton

CITY OF BALTIMORE: (No. 12 ~~Bond~~ ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie D. Koetting

(a) RESIDENCE NO. 120 Hoffman Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Koetting

6 DATE OF BIRTH (month, day, and year) Feb 2 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nedary Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Hummer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs A. Miller

(Address) 603 N Luzerne Ave

15 Filed JAN 8 — 1922 19 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 25 1921 to Jan 6 1922

that I last saw h alive on Jan 6 1922

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis + Pulmonary oedema.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio sclerosis + Interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Summers, M. D.

Jan 6 19 22 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 9 1922
20 UNDERTAKER	ADDRESS
Wm C. Miller	2339 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Consult physician if necessary. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Infirmities of Age," "Senility," "Natural Causes," "Unknown," etc., are not sufficient. Do not use abbreviations or initials. Do not state mode of dying, such as "Collapse," "Coma," "Asphyxia," etc., but the cause which produced it. If from accident, violence, or casualty, state the nature of the injury and the means by which it was inflicted. If from disease, state the name of the disease. If from childbirth, state the fact. If from a specific disease, state whether the diagnosis was confirmed by a physician. If the deceased was a female, state whether pregnant or recently delivered. If from violence, state whether accidental, suicidal, or homicidal. If the death was caused directly or indirectly by the criminal act of another, give name, if known, and whether arrest has been made. If the death was caused directly or indirectly by the use of alcohol, state the fact. If the death was caused directly or indirectly by the use of narcotics, state the fact. If the death was caused directly or indirectly by the use of tobacco, state the fact. If the death was caused directly or indirectly by the use of opium, state the fact. If the death was caused directly or indirectly by the use of cocaine, state the fact. If the death was caused directly or indirectly by the use of morphine, state the fact. If the death was caused directly or indirectly by the use of chloroform, state the fact. If the death was caused directly or indirectly by the use of ether, state the fact. If the death was caused directly or indirectly by the use of chloral, state the fact. If the death was caused directly or indirectly by the use of bromides, state the fact. If the death was caused directly or indirectly by the use of barbiturates, state the fact. If the death was caused directly or indirectly by the use of amphetamines, state the fact. If the death was caused directly or indirectly by the use of LSD, state the fact. If the death was caused directly or indirectly by the use of marijuana, state the fact. If the death was caused directly or indirectly by the use of heroin, state the fact. If the death was caused directly or indirectly by the use of cocaine, state the fact. If the death was caused directly or indirectly by the use of morphine, state the fact. If the death was caused directly or indirectly by the use of chloroform, state the fact. If the death was caused directly or indirectly by the use of ether, state the fact. If the death was caused directly or indirectly by the use of chloral, state the fact. If the death was caused directly or indirectly by the use of bromides, state the fact. If the death was caused directly or indirectly by the use of barbiturates, state the fact. If the death was caused directly or indirectly by the use of amphetamines, state the fact. If the death was caused directly or indirectly by the use of LSD, state the fact. If the death was caused directly or indirectly by the use of marijuana, state the fact. If the death was caused directly or indirectly by the use of heroin, state the fact.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60073

D 60073

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Patapsco Ave ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bernhardt Schneffe

(a) RESIDENCE. No. 513 Patapsco Ave ST., WARD. 25

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Schneffe

6 DATE OF BIRTH (month, day, and year) July 20 1843

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired gdn

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman C C Schneffe

(Address) 305 Potomac ave

15 Filed JAN 8 - 1922 19 ROBERT R. KRAUSER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Jan 6, 1922, that I last saw h in alive on Jan 6, 1922, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) H Lambert

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Brooke, M. D.

, 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 9 1922
20 UNDERTAKER John H Deany	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60074

CERTIFICATE OF DEATH.

H5

1-PLACE OF DEATH

REGISTERED NO. D 60074

CITY OF BALTIMORE: (No. 1742 E. Lafayette Ave ST.) (8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Drew Smith

(a) RESIDENCE. NO. 1742 E. Lafayette Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward S. Smith

6 DATE OF BIRTH (month, day, and year) Aug 28, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Elias Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Martha Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Va.

14 Informant Mr. Edward S. Smith
(Address) 1742 E. Lafayette Ave

15 Filed JAN 8 - 1922 ROBERT KUKRAUTER. Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Jan 6 1922, that I last saw her alive on Jan 6 1922, and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray.

(Signed) Elmer Gill Ball, M. D.

Jan 7 1922 (Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cy	Jan 9 1922

20 UNDERTAKER Jos Foerchers Son ADDRESS 2178 Pacific

CAUSE OF DEATH in plain terms, so that it may be understood by the people, and not by doctors alone. See back of certificates. TION is very important. See instructions on back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation); using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably originated around the sigmoid

Spec.—1-10-21—M&T—1500 Bks.

D 60075 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 60075

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4 Traymore Road (Hamilton ST., 54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett E. Coulter

(a) RESIDENCE NO. Carney Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Coulter

6 DATE OF BIRTH (month, day, and year) April 23rd 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel W. Hollyerroy

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catharine Streback

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant John Coulter
(Address) Carney Md.

15 Filed JAN 8 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1922, to Jan 5, 1922

That I last saw h er alive on Jan 5 1922

and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy
(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Biliary calculi
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Blanche Long M. D.

Jan 7 1922 (Address) 27 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan. 9 1922
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60076 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

49 D 60076

REGISTERED NO.

1-PLACE OF DEATH South Balto Gen. Hospital

CITY OF BALTIMORE: (No. 1215 Light ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Redmond

(a) RESIDENCE NO. 1134 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jessie Redmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Redmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Julia Redmond

(Address) 1134 Lombard St Balto

15 Filed JAN 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1922, to Jan 8, 1922.

that I last saw him alive on Jan 8, 1922,

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ast Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jan 10 Robert Alderson M. D.

, 19 (Address) South Balto Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount View Howard Co — DATE OF BURIAL Jan 10 1922

20 UNDERTAKER Easton Sons — ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

60077 HEALTH DEPARTMENT—CITY OF BALTIMORE 1001 60077

D 60077 CERTIFICATE OF DEATH. 74 D 60077

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE (No. 1422 N. Mount St. 15 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Griffin

(Residence in Baltimore: No. 1422 N. Mount) (Not; yrs., 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male | 4-COLOR OR RACE: colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, July 4, 1879 (Month) (Day) (Year)

7-AGE, 42 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer): 073

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, ~~Jos~~ Allen Griffin

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Davis Keen

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. Griffin

(Address) 1422 N. Mount St.

15- Filed JAN 8 - 1922 191 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbuncle Thumb

(Duration) 3 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. E. Hennessy, M. D. (Coroner.)

Jan. 5, 1922 (Address) 7 S. Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Edw McCarthy | DATE OF BURIAL, Jan 6, 1922

UNDERTAKER: Edw Ingold | ADDRESS Jan 5 1922 1463 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.-1-10-21-M&T-1500 Bks.

D 60078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60078

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Bolton St. ST., 14 WARD)

2-FULL NAME Talbot Winchester Jenkins

(a) RESIDENCE NO. 1509 Bolton St. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Banks Jenkins

6 DATE OF BIRTH (month, day, and year) May 18, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler 038

(b) General nature of industry, business, or establishment in which employed (or employer) Silversmith

(c) Name of employer self.

9 BIRTHPLACE (city or town) Memphis (State or country) Tennessee

PARENTS

10 NAME OF FATHER George Jenkins

11 BIRTHPLACE OF FATHER (city or town) New Green (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lydia M. Armour

13 BIRTHPLACE OF MOTHER (city or town) Girardeau (State or country) Missouri

14 Informant R. Hillen Jenkins (Address) 2925 St. Paul St.

15 Filed JAN 9-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1921, to Jan. 8, 1922, that I last saw him alive on Jan. 7, 1922, and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocardial insufficiency (Duration 2 wks.)

Arteriosclerosis (duration) about yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Mary A. Hodge, M. D.

, 19 (Address) 943 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 10 1922
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Son	Edward Mc Colloch

CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 60079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mondebella & Fillmore (WARD) 9th

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Koons.

(a) RESIDENCE No. Mondebella & Filmore 9th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of late Thomas Koons.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
71				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Wife

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Martin Kelley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kelley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Mary Koons.
(Address) Mondebella & Fillmore

15 Filed JAN 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany, 1920, to Jany 7, 1922.

that I last saw her alive on Jany 6, 1922;

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of the heart

(duration) 2 yrs. mos. / ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical attention

(Signed) Thomas Westbrook, M. D.

Jan 7, 1922 (Address) 1418 Goodrich ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 9 1922

20 UNDERTAKER	ADDRESS
George J. Ruth	1225 Hayford ave.

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

60080

HEALTH DEPARTMENT—CITY OF BALTIMORE

60080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: [illegible] WARD) 26 179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Walter

(a) RESIDENCE. NO. Unknown ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JAN 9 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

CAUSE OF DEATH IN DARK CRS. SHOULD BE REPORTED TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1922

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1922, to January 3, 1922, that I last saw h in alive on January 3, 1922, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Multiple, infected abrasion of legs

(over)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritic toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) L. A. Bamberger, M. D.

Jan. 4, 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Jan. 9th 1922
20 UNDERTAKER	ADDRESS
George J. Ruth.	1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60081

CERTIFICATE OF DEATH.

164 D 60081

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 822 N. Carrollton Ave ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Elizabeth Horton

(a) RESIDENCE. No. Presbyterian Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 20 1833

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER Jesse Horton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary C. Robb Supt.
(Address) 822 N. Carrollton Ave.

15 Filed JAN 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 — 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29 — 1921, to Jan. 7 — 1922, that I last saw h— alive on Jan. 3 — 1922, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

General Debility of old age about one year (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enantha (duration) about 2 or 4 months yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carlton McCook M. D.

, 19 (Address) 1107 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pimlico Cemetery Broadway & Clay Street

DATE OF BURIAL: Jan 9 1922

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. North Ave

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

D 60082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60082

CERTIFICATE OF DEATH.

74-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Cherry alley Rear 1680 Penna Ave 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis M. Simms

(Residence in Baltimore: No. Cherry alley Rear 1680 Penna Ave St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Don't Know, 1 .....
(Month) (Day) (Year)

7-AGE. 69 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer). D.S.

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Joseph Simms

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Anna Sourd.

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Gronwell

(Address) 2700 Edmondson

15- Filed JAN 9 - 1922, 191... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (Coroner, ~~autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

a Few hours
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Gramply M. D.
(Coroner)

1-9 1922 (Address) 17 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Jan 9, 19 22

20-UNDERTAKER Geo W. Little

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH to be plain terms, as may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60083

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 60083

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No..... ST.: 11 WARD)

2-FULL NAME George Albert Carpenter

(a) RESIDENCE. No. 1101 Maryland Ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year)

7 AGE: 33 Years ___ Months ___ Days | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland Born in Baltimore

PARENTS

10 NAME OF FATHER: William Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Born in Md

14 Informant (Address): Bay View Hospital Records.

15 Filed JAN 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 7 1922

17 I HEREBY CERTIFY, That I attended deceased from August 2nd 1921 to January 7 1922.

that I last saw him alive on January 7 1922.

and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Luetic Infection

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Serological test

(Signed) H. Goldsmith, M. D.

. 19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery

DATE OF BURIAL: Jan 11 1922

20 UNDERTAKER: Chas H A Elliott

ADDRESS 1725 Ashland Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT IS SECURED TION is very important. See instructions on back of certificates.

Spec.—6-6-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60084

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST.: 18 WARD)

2-FULL NAME Charles Hawkins

(a) RESIDENCE. No. 723 N Poppleton St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29th 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore Md.

PARENTS

10 NAME OF FATHER James Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Clara Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address)

15 Filed JAN 9 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1921, to Jan 6th, 1922, that I last saw him alive on Jan 6th, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endocarditis & DTW
Bronchio-pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Horace G. Stewart, M. D.

1/7, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan 1922
20 UNDERTAKER	ADDRESS
Robert A Elliott	1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used. Information required is important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 60085

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Arlington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Reina

(a) RESIDENCE. No. 9 S. Arlington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wilhelm Reina

6 DATE OF BIRTH (month, day, and year): Feb 6 1843

7 AGE — Years: 78 — Months: 11 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Schmiel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Bertha Keil
(Address) 9 S Arlington Ave.

15 Filed: JAN 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain words. Indefinite answers will not be accepted. Information is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 24 1921 to Jan 6 1922.

that I last saw h alive on Jan 6 1922.

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Infirmities of Old age

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Gennaly

(Signed) H. H. Campbell M. D.

Jan 7, 1922 (Address) 644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 9 1922
20 UNDERTAKER	ADDRESS
George J Smith	1000 E Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60086

CERTIFICATE OF DEATH.

90 D 60086

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 274 Loudon ave ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah. Spurrier

(a) RESIDENCE. No. 274 Loudon ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colute	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm Beal Spurrier

6 DATE OF BIRTH (month, day, and year) apr 3-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant H Placedi
(Address) 274 Loudon Av

15 Filed JAN 9—1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1919 to Jan 6 1922
that I last saw her alive on Jan 5 1922
and that death occurred, on the date stated above, at 6 15 a. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert E Mitch M. D.
1/4 1922 (Address) 2157 Baltimore ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 7 1922

20 UNDERTAKER George J Smith & Fayette ADDRESS 1000

CAUSE OF DEATH in plain terms, so that it may be readily understood. Do not use abbreviations or technical terms. Consult the Physician if necessary. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60087

D 60087

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Phillippe (or Jacob philippe)

(a) RESIDENCE. No. 415 Courtland st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER Peter Philippe

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Hospital Records (Address) M.T.H.

15 Filed JAN 9- 1922 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1921, to Jan. 5, 1922, that I last saw him alive on Jan. 4, 1921, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Francis L. Dedeglisse, M. D.

1-5-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 JAN 7 1922

20 UNDERTAKER Commissioner Health.

ADDRESS

For Wm. E. WOODALL

CAUSE OF DEATH must be plainly filled in, and all questions answered. Neglect of certificates. See instructions on back of TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60088

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 60088

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2439 Jamietta ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Conrad Dietz

(a) RESIDENCE. No 2439 Jamietta ave ST., 20 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina C Dietz

6 DATE OF BIRTH (month, day, and year) April 13th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret- Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Self 017

(c) Name of employer Self Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Henry Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Conrad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Wilhelmina Dietz
(Address) 2439 Jamietta ave

15 Filed JAN 9 1922, 19... ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Jan 3, 1921, that I last saw h.. alive on Jan 5, 1921, and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Duration ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thalm Gorman, M. D.

1/9, 1922 (Address) 3405 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 9th 1922

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2506 Edmondson ave

CAUSE OF DEATH should be stated by the physician in plain English. Use of abbreviations or technical terms should be avoided. ATTENDING PHYSICIAN is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60089

CERTIFICATE OF DEATH.

REGISTERED No. 29

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Adams

(a) RESIDENCE. No. 127 Albemarle St, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White (Lithuanian)	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Veronica Adams

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer Not Known

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Michael Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Catherine Dargolas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania.

14 Informant Mrs. Veronica Adams

(Address) 127 Albemarle St.

15 Filed JAN 9-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7 1922

17 I HEREBY CERTIFY, That I attended deceased from 10 a.m. 1/7, 1922, to 5 p.m. 1/7, 1922, that I last saw him alive on January 7, 1922, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Acute Tetanus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gunshot wound right fingers left hand. (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 127 Albemarle St.

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Cyrus F. Hoxie, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Janv 11 1922
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St.

CAUSE OF DEATH in plain terms. Abbreviations not allowed. Physician's certificate must be filed with Registrar within 24 hours after death. BURIAL PERMIT cannot be issued until certificate is filed. See reverse side for additional information. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

60090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 60090

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough Apts. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Flesinger

(a) RESIDENCE NO. Marlborough Apts. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty Flesinger

6 DATE OF BIRTH (month, day, and year) 4-21-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail 045

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe

(c) Name of employer Merchant Baltimore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Moses Flesinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elane Prag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Albert Flesinger (Address) Marlborough Apts.

15 Filed JAN 9 - 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 7 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 22 1921 to Jany 7 1922

that I last saw him alive on Jany 7 1922

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs — mos 5 ds.

CONTRIBUTORY (Secondary) Chronic nephritis, hypertension, myocarditis, Symptoms (duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis P. Hamburger, M. D.

1/8, 1922 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	1/9 1922
20 UNDERTAKER David Sondheim	ADDRESS 1116 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60091

HEALTH DEPARTMENT—CITY OF BALTIMORE

99,001

D 60091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 E. North Ave ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Virginia Knight

(a) RESIDENCE. No 1605 E. North Ave - ST., / WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 5 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24/1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. C. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Carolina Leyhe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Carolina Knight
(Address) 1605 E. North Ave -

15 JAN 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4 1922, to Jan 6, 1922, that I last saw her alive on Jan 6 1922, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elmer Gill Hall, M. D.

Jan 8 1922 (Address) 1617 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem.	Jan 9th 1922
20 UNDERTAKER	ADDRESS
Philip Herwig	Orleans St.

CAUSE OF DEATH to be filled in plainly, preferably with pen, and without abbreviation. See instructions on back of certificates.
TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
No further history
than bronchitis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60092

CERTIFICATE OF DEATH.

162 D 60092

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sullivan

(a) RESIDENCE. NO. 160 Virginia Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John E. Sullivan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen R. Kailer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital record
(Address)

15 Filed . 19
JAN 9 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1922, to Jan 9, 1922
that I last saw her alive on Jan 9, 1922,
and that death occurred, on the date stated above, at 5 A m.
The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.
1-9, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Jan. 9 1922

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Falls Rd

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—1-10-21 M&T 1500 Blks.

D 60093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 D 60093

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (NO. N. Broadway ST., 1 WARD)

2-FULL NAME George Barnstorf

(a) RESIDENCE NO. 535 E. Clinton St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Barnstorf

6 DATE OF BIRTH (month, day, and year) Nov 4 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33	2		

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Refg & smelting

(c) Name of employer Baltimore Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Barnstorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Dora Barnstorf
(Address) 1923 Clinton

15 Filed JAN 9-1922, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1922, to Jan 7, 1922, that I last saw her alive on Jan 7, 1922, and that death occurred, on the date stated above, at 9:35 A. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

2 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum.

2 (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Dec 24, 1922

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Wm. H. Kable, M. D.

, 19 (Address) same

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartze — DATE OF BURIAL Jan 10 1922

20 UNDERTAKER Pickard & Pickard — ADDRESS 739 E. Eager

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. Any one who shall make a false statement of the cause of death or who shall refuse to make a certificate of death shall be guilty of a misdemeanor and subject to a fine of not more than $100 for each offense. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

60094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60094

CERTIFICATE OF DEATH

38

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. Kramer

(a) RESIDENCE. No. 3302 Hudson St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11-1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	10	27	

8 OCCUPATION OF DECEASED 048

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hospital Reads (Address)

15 Filed JAN 9-1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8th 1922

17

I HEREBY CERTIFY, That I attended deceased from August 17th, 1921, to January 8th, 1922, that I last saw he alive on January 8th, 1922, and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No Clinical & Serological tests

What test confirmed diagnosis?

(Signed) H. Goldschmidt, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Jan 11 1922
20 UNDERTAKER Fiekler & Fiekler E.J.F.	ADDRESS 1739 Eager

THON is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60095

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 001

101 D 60095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Fleet ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth ~~Catherine~~ Elmer

(a) RESIDENCE. No. 2308. Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Elmer

6 DATE OF BIRTH (month, day, and year) May 12-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Brockel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Schroeder

(Address) 2308 Fleet St

15 Filed JAN 9 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany 7th, 1922, to , 19 , that I last saw her alive on Jany 7th, 1922, and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt N. Bilsey, M. D.

Jan 8. 1922 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dolfield Reformed Cem	Jan 11 1922
20 UNDERTAKER	ADDRESS
J. Young & Co	2008 Eutaw

TION is very important. See instructions on back of certificates.

GENERAL AFFIDAVIT — LUCAS BROS., INC., FORM 56

State of Maryland, Baltimore City, to wit:

BE IT REMEMBERED, *That on this* 16th *day of* January

*A. D. 19*22, *before me, the subscriber, a* .....

of the said State, in and for the City aforesaid, personally appeared

Dr Caleb N Athey
100 Patterson Park ave.

and made oath in due form of law that .....

Through an error in the name, he filed with the health dept. of the City of Baltimore a certificate of death giving the name as Catherine Elm whereas the correct name of the deceased should be written Elizabeth Elm. and further swears that the correct age is 78yrs-9mo-25da

Caleb N Athey M.D.

Subscribed and sworn to before me this 16th day of January 1922

Leuder M Lewis
Notary Public

My Commission Expires
May 3, 1922.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 60096

HEALTH DEPARTMENT—CITY OF BALTIMORE

36 D 60096

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Rice ST.; 17 WARD)

2-FULL NAME William Robinson

(a) RESIDENCE. No. 825 Rice ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Color	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer Asso Canning Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Robinson (Address) 825 Rice St

15 Filed JAN 9 - 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1921 to Jan 5 1922 that I last saw him alive on Jan 5 1922 and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows: (?)

Imperfect leg (T.B.) Explanation

(duration) 0m yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John R Crosby M. D.

. 19 (Address) 72-3 Hoya St

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rosedale Hugh Middle Dep 66 Va	Jan 10 1922
20 UNDERTAKER	ADDRESS
Brown & Friedlander	1145 Lexington St

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lung not involved.
Probably tuberculous
leg.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60097

D 60097

161-002

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3901 W. Hamilton Av. (West Arlington WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Henry Wintz

(a) RESIDENCE. (No.) 3901 W. Hamilton Av. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 24-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Harry L. Wintz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmington Del.

12 MAIDEN NAME OF MOTHER Regina L. Bates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Edwin B. Fenby

(Address) 1223 N. Carolina St.

23 Filed JAN 9 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 — 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1921, to Jan. 8, 1922, that I last saw him alive on January 7, 1922, and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Presure on brain due to difficult birth

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

1/8/1922 Address 1223 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 9 1922
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	114 Guenmit St.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 N. East Ave. ST., 26 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily C. Mullikin

(a) RESIDENCE NO. 617 N. East Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late William Mullikin

6 DATE OF BIRTH (month, day, and year): Jan 2nd 1846

7 AGE: Years 76 | Months — | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Nellie G. Holmes
(Address): 617 N. East ave

15 Filed JAN 9 - 1922 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to Jan 8, 1922 that I last saw h[illegible] alive on Jan 7, 1922 and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis + arteriosclerosis. Cerebral Embolism

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 6, 1922 Address 47 66 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan 9 1922

20 UNDERTAKER: Henry Kouck & Son — ADDRESS: 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly coded. Information on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60099 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60099

CERTIFICATE OF DEATH.

14-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 2605 Greenmount Ave. 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Leyrer

(a) RESIDENCE. No. 2605 Greenmount Ave Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? 70 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adulate Helen Leyrer

6 DATE OF BIRTH (month, day, and year) Oct 25th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Otb

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor-

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Stephen Leyrer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Schmitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. Philbin R. Leyrer

(Address) 2605 Greenmount Ave

15 Filed JAN 9-1922, 19... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to Jan 8, 1922, that I last saw h alive on Jan 8, 1922, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. C. Richardson, M. D.

Jan 9, 1922 (Address) 1142 N. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 10 1922

20 UNDERTAKER Henry Hoerle Son ADDRESS 1301 E. Eager St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—M. P. Co.—1000 Bks.

13283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60100

CERTIFICATE OF DEATH.

101-001 D 60100

1-PLACE OF DEATH

CITY OF BALTIMORE: No. ST.: 4 WARD

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Teit

(a) RESIDENCE. No. 257 Redwood St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 9th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER John Teit

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Emma Whitehall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Records

15 Filed JAN 9 - 1922 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28th, 1921, to Jan 2nd, 1922, that I last saw him alive on Jan. 1st, 1922, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) — yrs. — mos. 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray. Blood Chemistry

(Signed) Francis R. Dieuaide, M. D.

Jan 6, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19 JAN 1922
20 UNDERTAKER	ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60101 58-001 D 60101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2522 N. Calvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Lucretia Carman

(a) RESIDENCE. NO. 2522 N. Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Mar. 12, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford County, Maryland

PARENTS

10 NAME OF FATHER Robert R. Carman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER Mary E. Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Mary E. Jenkins

(Address) 2522 N. Calvert Street

15 FILED JAN 9-1922 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921. to June 8, 1922.

that I last saw h alive on June 7, 1922.

and that death occurred, on the date stated above, at 5, 15a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Relapse

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Walter Thomas, M. D.

June 10 1922 (Address) 1224 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	1/10, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60102

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

90 D 60102

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 N. Payson ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Anna Roth

(Residence in Baltimore: No. 710 N. Payson St St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Apr. (Month) 20 (Day), 1865 (Year)

7-AGE, 56 yrs. 8 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, August Klinger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Roth

(Address) 710 N. Payson St.

15-

Filed JAN 9 - 1922 191.. ROBERT J. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 6 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to Jan 6 1922, that I saw h in alive on Jan 6 1922 and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) 5 yrs. 5 mos. 21 ds.

(Signed) W. S. Love M. D.

Jan 9, 1922 (Address) 836 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Jan 9, 1922

20-UNDERTAKER Geo. L. Schwab & Bro

ADDRESS 2101 Eutaw Pl.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60103

CERTIFICATE OF DEATH.

REGISTERED No. C 18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 Dover St ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helena M - Boyd

(Residence in Baltimore: No. 1815 Dover St St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Baby

6-DATE OF BIRTH, April (Month) 13 (Day), 1918 (Year)

7-AGE, 3 yrs. 7 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), 1822 Nicholson St

PARENTS.

10-NAME OF FATHER, Robert Milton Boyd

11-BIRTHPLACE OF FATHER (State or Country), Balto - Md.

12-MAIDEN NAME OF MOTHER Lillian M. Howard

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Milton Boyd

(Address) 1815 Dover St

15-

Filed....., 191.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9th 1922 to Jan 9 1922, that I saw her alive on Jan 9 1922 and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria.

(Duration) .....yrs. 2 mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) D. F. Mackabee M. D.

Jan 9, 1922 (Address) 130 W. Lafayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Jan 9, 1922

20-UNDERTAKER Harry H Witzke

ADDRESS 1534 W Lafayette

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Schreiner ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60104

D 60104

CERTIFICATE OF DEATH.

129

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Agatharine Schreiner

(Residence in Baltimore: No. Augusta Apt Ashland Ave ST.; 27 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August (Month) 10 (Day), 1843 (Year)

7-AGE, 78 yrs. 4 mos. 29 ds. | If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): 068

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Schreiner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Stuhl

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Bernard

(Address) Notre Dame Augusta St

15-

Filed ....., 191.....

Registrar.

9-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1921, to January 1922, that I saw h.. alive on 1922, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Arteriosclerosis,
Chronic Arthritis Deformans

(Duration) Years mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. J. Kelly M. D.

1/9, 1922 (Address) 110 E. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Notheliffe - Md. | DATE OF BURIAL. Jan. 10, 1922

20-UNDERTAKER F. Flint Gaynor | ADDRESS 915

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60105

CERTIFICATE OF DEATH

X 44

1-PLACE OF DEATH { Union Memorial Hospital
CITY OF BALTIMORE: No. { Union Protestant Inf. ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Egbert Ashe Moore

(a) RESIDENCE. No. Currie N. Carolina ST., WARD. Currie N. C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) — 045
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS
10 NAME OF FATHER James B. Moore
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina
12 MAIDEN NAME OF MOTHER Mary E. Murphy
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanta Georgia

14 Informant Records Union Prot. Inf. (Address) Durham N. C.

15 Filed 9- 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1921, to Jan 8, 1922,
that I last saw him alive on Jan 8, 1922,
and that death occurred, on the date stated above, at 9:30 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. 6(?) mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? yes Date of Jan 5 1922
Was there an autopsy? no
What test confirmed diagnosis? Operation & clinical course.
(Signed) Jno. B. Finney Jr. M. D.
Jan 8 1922 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Currie N. C. Jan 9 1922

20 UNDERTAKER ADDRESS
John O. Mitchell 1201 W. Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 60106

B 60106

CERTIFICATE OF DEATH.

148

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.: 6 (Ward)

2-FULL NAME Vera M. Ratcliff

(a) RESIDENCE. No. 104 Jackson Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Gilbert A. Ratcliff

6 DATE OF BIRTH (month, day, and year) March 9, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work O. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Wm. B. Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Lillie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant
(Address)

15 Filed 19 Robert F. Harrison
Registrar

9-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1922, to Jan. 9th, 1922, that I last saw h[illegible] alive on Jan. 9th, 1922, and that death occurred, on the date stated above, at 2-40 P. M.

The CAUSE OF DEATH* was as follows:

Toxaemia of Pregnancy.
(Pernicious Vomiting)

(duration) ✓ yrs. ✓ mos. 13 ds.

CONTRIBUTORY ✓
(Secondary)
(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H H Cathrall M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bloomingdale Ind	Jan 9 1922

20 UNDERTAKER Joseph Ahrens
Bloomingdale Ind.

ADDRESS 221 N B Way

CAUSES OF DEATH. See instructions on back of certificates. IMPORTANT.

Stoc.—6-9-19—H. P. Co.—1000 Bks.

D 60107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60107

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1821 (Street) Little Walsh ST.; (Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dreyer

(a) RESIDENCE. No. 1821 Little Walsh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Elizabeth Dreyer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 208

(c) Name of employer: Packard Motor Co.

9 BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS

10 NAME OF FATHER: Bernard Dreyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant (Address): Mrs Emil Dreyer 1821 L. Walsh St.

15 Filed ~~Jan~~ Feb 7 1922, 19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to Jan. 8, 1922; that I last saw h[illegible] alive on Jan. 8, 1922; and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Chr. Encephalitis (duration) yrs. 6 mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Paul Brandt M. D.

1/7, 1922 (Address) 1837 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 11 1922

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

TION is very important. See instructions on back of certificates.

9-1922

Spec.—1-10-21—M&T—1500 Bks.

(See Letter over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60108

D 60108

JAN 20 1923

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1 PLACE OF DEATH

CITY OF BALTIMORE. (No. 1117 Sargeant Street ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Balthaser ~~Walter B.~~ Miller

GHG

(a) RESIDENCE NO. 1117 Sargeant Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Miller

6 DATE OF BIRTH (month, day, and year) May 20- 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimor Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles H. Miller

(Address) 1113 Sargeant Street

15 Filed AUG 22 1922 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1- 9- 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921, to Jany 9- 1922

that I last saw h alive on 19

and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Doma, M. D.

, 19 (Address) 1727 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimor Cemetery

DATE OF BURIAL 19

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms. So that a layman can understand. Check of certificates.
TION is very important. See instructions on back of

SHEPHERD DRAIN, M. D.
PHYSICIAN AND
SURGEON
1227-1229 COLUMBIA AVENUE

SURGEON TO
EMERGENCY HOSPITAL

JAN 20 1922

BALTIMORE, MD., Jany 19 1922

Dr C Hunt Jones
Care Health
Board City

Dear Sir

Change the name on
death cirtificate of Walter B Miller
1112 Sargant St died 1-9-22
to Balthaser Miller. He is
a pensioner and Walter was
a nick name. and will not
be acceptable to the government

Yours truly

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60109

CERTIFICATE OF DEATH.

17 D 60109

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josephs Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E. Penn

(Residence in Baltimore: No. 1805 Barcaly Street St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) Unknown ..... (Day) ..... (Year) 1

7-AGE, about 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Haynes

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Cecelia Shaw

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Penn

(Address) 1805 Barcaly St

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk. Registrar.

CAUSE OF DEATH. Information must be given for this line. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June ..... (Month) 7 ..... (Day), 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Femur
Accidental Fall
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

..... 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Park Cem. DATE OF BURIAL, 1-10, 1912

20-UNDERTAKER William Cook ADDRESS 502 E North Ave

D 60110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C [illegible]

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.: 27 WARD)
(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Raskott

(Residence in Baltimore: No. Falls Road 5th House Abov Bare Hill St.; yrs., 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, April 24, 1880
(Month) (Day) (Year)

7-AGE, 41 yrs. 8 mos. ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Landscape
(b) General nature of industry, business, or establishment in which employed (or employer)..... Gardner

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Bernard Raskott
11-BIRTHPLACE OF FATHER (State or Country) Germany
12-MAIDEN NAME OF MOTHER Clara ?
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clara A. Raskott
(Address) Falls Road 5th House Abov Bare Hill

15- Robert P. Harrison,
Filed ....., 191.....
1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
From Cystic Accident Fracture of Skull 3d
(Duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Shock 3
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. E. Clarke M. D.
(Coroner.)
Jan 7, 1922 (Address) 37 Bray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge
DATE OF BURIAL, June 10, 1922
20-UNDERTAKER William Cook per J.M.
ADDRESS S. & E. North Ave.

CAUSE OF DEATH must be filled in. All items important. See instructions on back of certificate.

9—1922

109 Penn Broadway

Spec. 6-8-19—H. P. Co.—1000 Blks.

D 60111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60111

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Jennie Bowers

(a) RESIDENCE. NO. Westminster, Md. ST.. WARD. Westminster Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. Clarence Bowers

6 DATE OF BIRTH (month, day, and year) unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46 years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. Mary G. Babylon Westminster, Md.

15 Filed Jan 9 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922. to Jan. 9, 1922.

that I last saw her alive on Jan. 9, 1922.

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Lung Abscess.

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No. Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) J. Willis Lynton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forrest Lawn Cemetery Md Fringlebung	Jan 12 1922

20 UNDERTAKER W. M. Robertson ADDRESS Sanatoga & Jones

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous. Primary
bronchopneumonia

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60112

CERTIFICATE OF DEATH.

REGISTERED NO. 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1114 W Lexington (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Jackson

(a) RESIDENCE. No. 1114 W Lexington St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of George Jackson (Dec'd)

6 DATE OF BIRTH (month, day, and year) — — 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Eugene Cooper
(Address) 1114 W Lexington St

15 Filed: Jan 9 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany 6, 1922, to Jany 8, 1922 that I last saw her alive on Jany 8, 1922 and that death occurred, on the date stated above, at 12.45 pm.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W F Howells, M. D.

1/9/1922 (Address) 114 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Baltimore Cem	Jan 10 1922
20 UNDERTAKER	ADDRESS
Brown & Fleharty	Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates.
TION is very important.

N 9-1922

D 60113

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 D 60113

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 421 N Exeter St. ST. 5 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alexander Collins

(Residence in Baltimore: No. 421 N. Exeter St St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: March 20 (Month) (Day), 1835 (Year)

7 AGE: 76 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Later
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balt

PARENTS

10 NAME OF FATHER: James Collins

11 BIRTHPLACE OF FATHER (State or country): Balt

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Collins

(Address) 421 N. Exeter st

15 FILED JAN 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 8 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1922 to Jan 8 1922 that I saw h... alive on Jan 6 1922 and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Apoplexy

(Duration) 10 yrs. mos. d

Contributory (SECONDARY)

(Duration) yrs. mos. d

(Signed) James M Preston M. D

Jan 9, 1922 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... d

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Jan 10 1922

20 UNDERTAKER: George J. Ruth

ADDRESS: 735 Hayford Ave

N. B.—Every item of information should be given as full as possible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60114

CERTIFICATE OF DEATH.

X 49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harrison

(a) RESIDENCE. No. 210 S. High St ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) Municipal Hospital

15 Filed JAN 10 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1922

17

I HEREBY CERTIFY, That I attended deceased from November 18 1921, to January 5, 1922, that I last saw him alive on January 5, 1922, and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Infected Malignant ulcer R. Lt. leg & thigh

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no Autopsy

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Bunbury, M. D.

1/6/, 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Jan 10 1922
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., **without more precise specification, as** *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer & Pulmonary Tuberculosis.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60115

CERTIFICATE OF DEATH.

90 D 60115

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1557 Leadie ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjie Penn

(a) RESIDENCE NO. 1557 Leadie ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Penn

6 DATE OF BIRTH (month, day, and year) Apr. 21 1857

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
64	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abraham Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charlotte Rice

(Address) 713 Baker Lane

15 Filed JAN 10 1922 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1921, to Jan 8, 1921.

that I last saw h alive on Jan 8, 1922

and that death occurred, on the date stated above, at 10:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Influenza

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Chandlee, M. D.

1922 (Address) 1504 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive	Jan 11 1922
20 UNDERTAKER	ADDRESS
Barnes Funeral Chapel	

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60116

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 1103 Etting ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emanuel Dorsey

(Residence in Baltimore: No. 1103 Etting St St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	Colored	Married

6-DATE OF BIRTH. Sept 12, 1899
(Month) (Day) (Year)

7-AGE. 22 yrs. 3 mos. 28 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE. (State or Country). City Balto

PARENTS.

10-NAME OF FATHER. Chas E Dorsey

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Van Wagner

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas E Dorsey

(Address) 1103 Etting St.

15-

Filed JAN 10 1922, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5th, 1922.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th 1921, to June 5th 1922, that I saw h[im] alive on June 5th 1922, and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis
(Acute)

(Duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion Produced

(Duration) yrs. mos. ds.

(Signed) E. S. Welch M. D.

Jan 23, 1922 (Address) 6 E. 7th St Charlestn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Jan 11, 1922

20-UNDERTAKER Edward McGowan

ADDRESS

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 60117

CERTIFICATE OF DEATH.

129

D 60117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 N. Calhoun ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Ellen Barnes

(a) RESIDENCE. No. 1115 N. Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Milton Barnes

6 DATE OF BIRTH (month, day, and year) 11-10-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) ppd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crisfield, Md.

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Crisfield Md.

12 MAIDEN NAME OF MOTHER Caroline Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Crisfield Md.

14 Informant Beasie Barnes
(Address) 1115 N. Calhoun st

15 Filed JAN 10 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8- 1922

17 I HEREBY CERTIFY, That I attended deceased from 1-3, 1922, to 1-8, 1922, that I last saw h e alive on 1-8, 1922, and that death occurred, un the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C Page, M. D.

, 19 (Address) 17 Dor. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jno Auburn Cmty	Jan 11 1922

20 UNDERTAKER ADDRESS

George H. Holland 168 1/2 Aug Hall

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60118

CERTIFICATE OF DEATH.

57 D 60118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 E Madison ST., 7 WARD)

2-FULL NAME Elizabeth A. Booth

(a) RESIDENCE NO. 1623 E Madison ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (~~HUSBAND of~~) or) WIFE of George W. Booth (Deceased)

6 DATE OF BIRTH (month, day, and year) June 6th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife ~~ppd~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas R Bernier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Miss Frances R Booth

(Address) 1623 E Madison st

15 Filed JAN 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1922, to Jan. 8, 1922, that I last saw him alive on January 7, 1922 and that death occurred, on the date stated above, at 6.35 a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine analysis

(Signed) Edwin B. Fenby, M. D.

1/9/1922 Address 1223 N. Gardiner st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 11th 1922
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60119

HEALTH DEPARTMENT—CITY OF BALTIMORE

172-002

D 60119

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Dukeland Ave ST. 16 WARD)

2-FULL NAME Charles Ross Ahl,

(a) RESIDENCE. NO. 907 Dukeland Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinest 031

(b) General nature of industry, business, or establishment in which employed (or employer) Int Clare Shops

(c) Name of employer B & O RR.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Ahl.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant John Patterson
(Address) 907 Dukeland Ave.

15 Filed JAN 10 1922 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8 1922

17 I HEREBY CERTIFY, That I attended deceased from December 28, 1921. to January 8, 1922.
that I last saw h im alive on January 8, 1922.
and that death occurred, on the date stated above, at 10:00 8 m.

The CAUSE OF DEATH* was as follows:
Atrophic Cirrhosis of Liver

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chester Riland, M. D.

1-4, 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL
Presbyterian Bon Secours Jan. 11 1922

20 UNDERTAKER ADDRESS
Wm J. Tickner & Sons N. & Pa

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60120

CERTIFICATE OF DEATH.

129 D 60120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2616 Frederick Ave. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily J. Hopkins

(a) RESIDENCE NO. 2616 Frederick Ave. ST., WARD

(Usual place of abode) Ellis Vine

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26th. 18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Hopkins

11 BIRTHPLACE OF FATHER (city or town) A. A. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Hush

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant Mrs. L. V. Knight
(Address) 2615 Frederick Ave.

15 Filed JAN 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8th 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to Jan 8, 1922,

that I last saw h[illegible] alive on Jan 7, 1922,

and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis
Myocarditis - Hypostatic
(No Tumor Pathology)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Howard W Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan. 10 1922
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Balto St.

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

D 60121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60121

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Oak ST.: 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Della Myers

(Residence in Baltimore: No. 2111 Oak St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 14, 1857
(Month) (Day) (Year)

7-AGE, 64 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER. Samuel Rinehart

11-BIRTHPLACE OF FATHER (State or Country). Dont Know

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hiram E. Myers

(Address) 2111 Oak Street

15-

Filed JAN 10 1922

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to Jan 8 1922, that I saw h[er] alive on Jan 7 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno Ebaugh M. D.

Jan 10, 1922 (Address) 700 W Lan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Park Wood Cem

DATE OF BURIAL, Jan 11, 1922

20-UNDERTAKER Hillian Cook

ADDRESS 502 N North Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60122

CERTIFICATE OF DEATH.

1922 D 60122

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bidder & Sellman Hospital (STREET OR WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver W Bubb

(Residence in Baltimore: No. 2840 Hundington Ave St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 20, 1916
(Month) (Day) (Year)

7-AGE, 5 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, Leni W Bubb

11-BIRTHPLACE OF FATHER (State or Country), MD

12-MAIDEN NAME OF MOTHER Agnes V Bubb

13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leni W Bubb

(Address) 2840 Hundington ave

15-

Filed JAN 10 1922, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from automobile accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Harrison M. D.
(Coroner.)

Jan 8 1922 (Address) 1122 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, Jan 12, 1922

20-UNDERTAKER Chenoweth & Son

ADDRESS Chestnut ave

D 60123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 D 60123

REGISTERED NO. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST. 17 WARD) (Barnes)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-FULL NAME J. Conard Gillard

(Residence in Baltimore: No. 2650 Bernard St. 33 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	single

6-DATE OF BIRTH, Jan. 15, 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, M. H. Gillard

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Addie Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Taylor

(Address) 2650 Bernard St.

15-

Filed JAN 10 1922, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit

CAUSE OF DEATH in plain terms. Do not use abbreviations or technical terms. Be particular and state the primary cause of death, the secondary cause, and the contributory cause, if any, in the order of their importance. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral meningitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) accidental, fall

(Duration) yrs. mos. ds.

(Signed) T. Hennessy M. D.
(Coroner)

Jan. 10, 1922 (Address) 332 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2650 Bernard

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Cem. DATE OF BURIAL, Jan. 11, 1922

20-UNDERTAKER Chenowethson ADDRESS Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

#5 D 60124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 806 S. Curley (St.) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth K. Zimmerer

(a) RESIDENCE. No. 806 S. Curley St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Zimmerer

6 DATE OF BIRTH (month, day, and year): June 14/1861

7 AGE — Years: 60 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Valentine Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. George Zimmerer
(Address) 806 S. Curley st

15 Filed JAN 10 1922 (19) ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to Jan. 8, 1922, that I last saw h[illegible] alive on Jan 7, 1922, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of April 1918

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Chas D. Reese, M. D.

1/9/22 (Address) 1085 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. — DATE OF BURIAL: Jan 12 1922

20 UNDERTAKER: Jos. J. Herr — ADDRESS: 156 N. Luzerne ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. State whether Accident, Suicide or Homicide. See instructions on back of certificates. TION is very important.

D 60125

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

65 D 60125

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Kerns

(Residence in Baltimore: No. 2035 E. Biddle St.: yrs. 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 24 (Day), 1894 (Year)

7-AGE, 27 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Salesman
(b) General nature of industry, business, or establishment in which employed (or employer), Hdw

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie M. Kerns

(Address) 2035 E. Biddle st.

15- JAN 1 0 1922 ROBERT R. KRAUTER, Filed ....., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Bichloride

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Jones M. D.

1-8 1922 (Coroner) (Address) 25 Leet.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem DATE OF BURIAL, Jan 11 1922

20-UNDERTAKER Jos. J. Iden ADDRESS 156 N. Luzerne ave.

CAUSE OF DEATH must be filled in plainly and completely. Every question important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60126

CERTIFICATE OF DEATH.

100 D 60126

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 Parrish St. St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Wooden

(a) RESIDENCE. No. 436 Parrish St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4.	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER William E Wooden

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Mulligan

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mr Wm E Wooden
(Address) 436 Parrish St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to June 8, 1922,
that I last saw h[illegible] alive on June 7, 1922,
and that death occurred, on the date stated above, at 8 10 a. m.
The CAUSE OF DEATH* was as follows:

Bronchus Pneumonia
(duration) ....yrs. ....mos. 3 ds.
CONTRIBUTORY (Secondary) Acute Bronchitis
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ———
Did an operation precede death? No Date of ———
Was there an autopsy? No
What test confirmed diagnosis? ———
(Signed) Edgar E Tower, M. D.
19 (Address) 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	June 10th 1922
20 UNDERTAKER: John Conway & Son Bur's & Cowan	ADDRESS: 908 Hollins St.

CAUSE OF DEATH in plain terms, so that any physician can understand it. See instructions on back of certificates. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60127

CERTIFICATE OF DEATH.

101-001

D 60127

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 109 Penn St— ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wade

(a) RESIDENCE. No. 109 Penn St— ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 086

(b) General nature of industry, business, or establishment in which employed (or employer) Ex Soldier.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mr Howard. Wain (Address) 109 Penn St

15 Filed JAN 10 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to Jan. 7, 1922, that I last saw him alive on Jan. 7, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stanley Strong, M. D.

Jan 10. 1922 (Address) 729 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	Jan 11th 1922
20 UNDERTAKER	ADDRESS
Jos Wm Gowan Son. Jos J Gowan	901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60128

CERTIFICATE OF DEATH.

D 60128

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 558 N. Biddle ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Pride

(Residence in Baltimore: No. 558 N. Biddle St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec (Month) 20 (Day), 1869 (Year)

7-AGE, 52 yrs. mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, George W. Pryor

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Richmond

13-BIRTHPLACE OF MOTHER (State or Country), Richmond

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy Pride

(Address) 444 N. Biddle

15-

Filed JAN 1 0 1922, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1921, to Jan 9 1922, that I saw her alive on Jan 8 1922 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Erysipelas

(Duration) yrs. 1 mos. 20 ds.

(Signed) J. A. Meekins M. D.

1-9, 1922 (Address) 1126 Druid Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Richmond Va

DATE OF BURIAL, Jan 11 1922

20-UNDERTAKER Samuel Hendley

ADDRESS 558 N. Biddle

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60129

D 60129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 751 Dolphin St.

REGISTERED NO.....

CITY OF BALTIMORE: (No. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Helmsley.

(a) RESIDENCE. NO. 751 Dolphin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Annie Helmsley

6 DATE OF BIRTH (month, day, and year) July 3, 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 090

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel Caswell.

(c) Name of employer Harry Busick

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER Jack Helmsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co, Md.

12 MAIDEN NAME OF MOTHER Annie Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md.

14 Informant Mrs Annie Hemsley (Address) 751 Dolphin St. C

15 Filed JAN 10 1922 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 29th 1921, to Jan 7th 1922, that I last saw him alive on Jan. 6th 1922, and that death occurred, on the date stated above, at 11.30 a-m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Argyle Car,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Chemical Findings

(Signed) J Bunnell Fenger, M. D.

, 19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 10 19 22

20 UNDERTAKER Samuel Hemsley ADDRESS 578 Middle

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60130

CERTIFICATE OF DEATH.

D 60130

REGISTERED NO. 472 D 60130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Druid Hill Av ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Thomas

(a) RESIDENCE. (Usual place of abode) No. 2111 Druid Hill Av ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Josephine Thomas~~

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Ford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Mrs Estander Thomas (Address) 2111 Druid Hill Ave.

15 Filed JAN 1 0 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Jan 7, 1922, that I last saw her alive on Jan 7, 1922, and that death occurred, on the date stated above, at 3-0 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes Date of Jan 7, 21

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. E. Higgins, M. D.

June 9, 1922 (Address) 1413 D. Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 10 1922
20 UNDERTAKER	ADDRESS
Samuel J Hemley,	578 W Fayette St

mation should be carefully supplied. Age should be stated EXACTLY. Information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See Letter attached)

D 60131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60131

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Hospital St.: No Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Boston

(a) RESIDENCE. No. Unknown St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46 (63) (appears 55?)	50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JAN 10 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1922, to January 7, 1922, that I last saw him alive on January 7, 1922, and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

1/9/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Jan 10th 1922

20 UNDERTAKER Wm J. G. Jackson ADDRESS 106 East St

TION is very important. See instructions on back of certificates.

D60131

MENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

MAR HOLLYDAY,
SUPERINTENDENT
H. CURRY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

January 12,1922

Health Department of Baltimore.
Bureau of Registration.
Baltimore, Md.

Gentlemen:-

The age of Joseph Boston is unknown. The aged as given by his neice is 46. He appeared to be 50 or 55 years old.

Very truly yours,

O'Neil
Resident Physician.

CMcN?MAH.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60132

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 60132

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No Park Heights Ave & Ford's Lane ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Catherine Surman

(a) RESIDENCE. No. Park Heights Ave & Ford's Lane ST., 27 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 55 yrs. ? mos. ! ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles August Surman

6 DATE OF BIRTH (month, day, and year) Feby-18-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Hanover Germany

PARENTS

10 NAME OF FATHER Geo Bunneke

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Hanover (State or country) Germany

14 Informant Miss Bertha Surman (daughter) (Address) Park Heights Ave & Ford's Lane.

15 Filed JAN 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922, to Jan 8, 1922, that I last saw h[er] alive on Jan 8, 1922, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ! ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) M D Corpus M.D.

1/9, 1922 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Jany-10-1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 109 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 60133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2908 Norfolk Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Jurney

(a) RESIDENCE. NO. 2908 Norfolk Ave ST. 15 WARD. (Residence)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 64 yrs. 9 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Clara Shane Jurney

6 DATE OF BIRTH (month, day, and year) March 27-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Oysters

(c) Name of employer Rowe & Jurney Co

9 BIRTHPLACE (city or town) (State or country) South River A.A.Co Maryland

PARENTS

10 NAME OF FATHER William Hall Jurney

11 BIRTHPLACE OF FATHER (city or town) (State or country) South River A.A.Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Linthicum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South River A.A.Co. Md.

14 Informant Mrs Clara Shane Jurney (Wife)
(Address) 2908 Norfolk Ave

15. Date Received JAN 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

'TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Janiy 9th. 1922

17 I HEREBY CERTIFY, That I attended deceased from Janiy 6th, 1922, to Janiy 9th, 1922, that I last saw him alive on Janiy 6th, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

OVER

at least (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Coma, about 2 ds.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of X

Was there an autopsy? No.

What test confirmed diagnosis? General Symptoms

(Signed) Calvin C. Price, M. D.

, 19 (Address) 101 - Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. OLIVET CEMETERY	Jan-11-22

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 103 W. NORTH AVE.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No cerebral hemorrhage.
Coma due to premature senile dementia.
Phy. only attended short time and could give no further history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60134

CERTIFICATE OF DEATH.

D 60134

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hugh Holland

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1895 Aug 29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	--4	--11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER James Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co., Maryland

12 MAIDEN NAME OF MOTHER Sarah Haney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed JAN 10 1922, 19 ROBERT R. KRAUTH, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from January 8, 1922, to January 9, 1922, that I last saw h im alive on January 8, 1922, and that death occurred, on the date stated above, at 6:55 A.M.

The CAUSE OF DEATH* was as follows:

Renal insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) 7 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

1/9/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 12 1922
20 UNDERTAKER	ADDRESS
J Herwig & Co	2008 Orleans

(See instructions on back of certificates. THIS is very important.)

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60135

CERTIFICATE OF DEATH.

161-001 D 60135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 5 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stanton

(a) RESIDENCE. No. 5 N. Exeter ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	—	—	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child 000
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Donald Stanton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Stella ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant
(Address)

15 Filed JAN 1 0 1922 19 ROSCHT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1922, to Jan 7th, 1922, that I last saw h[illegible] alive on Jan 7th, 1922, and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Coroner

(Signed) Horace G. Stewart, M. D.

1/8, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1-10 1922
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E Baltimore

TION is very important. See instructions on back of certificates.

Ulrich Billing

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60136

CERTIFICATE OF DEATH.

179

D 60136

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Jos. Hospital No 16 ST.: WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ulrich Billing

(Residence in Baltimore: No. 530 S 3rd St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH. ..... June (Month) 30 (Day), 1897 (Year)

7-AGE. 24 yrs. 6 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George Billing

11-BIRTHPLACE OF FATHER (State or Country), Ger.

12-MAIDEN NAME OF MOTHER Catherine Portzell

13-BIRTHPLACE OF MOTHER (State or Country), Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Billing

(Address) 530 S. 3rd St

15- JAN 10 1922

Filed....., 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, clothing Cont.

Fire while Smoking Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... Duration yrs. mos. ds.

(Signed) John Fuller M. D.
(Coroner.)

1—9—, 1922 (Address) 41 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Jan. 11, 1922

20-UNDERTAKER Lilly & Zuber ADDRESS 403 S. Wolfe St

CAUSE OF DEATH must be stated in plain terms. Indefinite or unusual terms will not be accepted. Every question must be answered if possible. Physicians are requested to fill out certificates promptly and accurately, as they are important. See instructions on back of certificate.

Spec.—6-9-19—H. F. Co.—1000 Bks.

D 60137 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60137

CERTIFICATE OF DEATH.

REGISTERED NO. 107-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1319. Richardson 24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustaf. Mildenberger

(a) RESIDENCE. No. 1319. Richardson WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Florist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Mildenberger

(Address) 1319 Richardson

15 Filed JAN 4 1932 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1922, to Jan 8 1922, that I last saw h... alive on Jan 8 1922, and that death occurred, on the date stated above, at 11-5 p. m.

The CAUSE OF DEATH* was as follows:

Lymphoma Mes.

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Kidney Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. G. Parr, M. D.

(Address) 801 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cal. DATE OF BURIAL: Jan 11 1922

UNDERTAKER: Wm. Fialkowski ADDRESS: 1618 East

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Referred to Hopkins Hospt by Dr Marr.
Diagnosis at Hopkins was abscess lung. Uncertain as to cause. Sputum test negative for tuberculosis. Operation at Hospt. for drainage of abscess.

D 60138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 60138

REGISTERED NO. C.....

(PLACE OF DEATH

CITY OF BALTIMORE (No. 715 S. Bond ST. W WARD)

2-FULL NAME Peter Kabacynka. (Kabacik)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 715 S Bond St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	White	Single

6-DATE OF BIRTH,

....., 1 .....
(Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benedict Jachemski

(Address) 830 S. Bond St

15-

JAN 1 0 1922

Filed ....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 6, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Tyler M. D.
(Coroner)

1-7- 1922 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	1/11/22 19....
20-UNDERTAKER	ADDRESS
Wm. F. Malkowski & S.S.C.	1818 Eastern

CAUSE OF DEATH in plain terms. All items must be filled in. See instructions on back of certificate.

Spesc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60139

CERTIFICATE OF DEATH.

X 111-00 ✓

D 60139

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Ind Gen Hospt ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Arnold

(a) RESIDENCE. NO. Rustletown Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno W Arnold

6 DATE OF BIRTH (month, day, and year): Jan 5 1859

7 AGE: Years 63 | Months — | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Riverside Md

PARENTS

10 NAME OF FATHER: George Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Ida Mitchell

(Address): Rustletown Md.

15 Filed JAN 10 1922 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/4/22, 19 , to 1/9/22, 19 , that I last saw h[illegible] alive on 1/9/22, 19 , and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Gastro duodenal Ulcer.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1/7/22

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Geo A Hyman, M. D.

, 19 (Address) Rustletown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan 13 1922
20 UNDERTAKER	ADDRESS
J. F. Eckis	Rustletown

IRON is very important. See INSTRUCTIONS on BACK OF CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60140

D 60140

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 N Gilmor ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Marie Atkins

(a) RESIDENCE NO. 237 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 5, 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	-	6 six.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William B. Atkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) white not Virginia

12 MAIDEN NAME OF MOTHER Mary Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Wm B Atkins

(Address) 237 N Gilmor St.

15 Filed 1 0 1922, 19 Expert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1922

17 I HEREBY CERTIFY, That I attended deceased from January 5 1922, to January 10 1922, that I last saw her alive on January 10, 1922, and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) James G. Murston, M. D.

(Address) 3908 Duval avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	1/10/22
20 UNDERTAKER Geo A Tuley	ADDRESS Fulton & Fayette

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Dr Feldner 1501 E Eager St. 9410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60141

CERTIFICATE OF DEATH.

58-09

D 60141

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 E. Biddle ST., 8 WARD)

2-FULL NAME Mary L. Lynas

(a) RESIDENCE NO. 2231 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas R. Lynas

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Rufus A. McDorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Summerset Co. Md.

12 MAIDEN NAME OF MOTHER Ursula Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Summerset Co. Md.

14 Informant Thomas R. Lynas (Address) 2231 E. Biddle St.

15 Filed JAN 11 1922, 19 S. Ellen Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany 10th, 19 22. to Jany 9th, 19 22.

that I last saw H alive on Jany 8th, 19 22, and that death occurred, on the date stated above, at 7.45 o. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Stone, M. D.

(Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Jan 12 1922

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Eden St.

CAUSE OF DEATH must be given plainly. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 60142 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60142

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (NO. Fort Mc Henry Baltimore Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ike Waters.

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., --- WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37 yrs.	---	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Merchant Seaman

(c) Name of employer ----------

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant E.T. Rosenbrock (Registrar)

(Address) US. PHS. Hosp. #56 Balto, Md.

15 Filed JAN 10 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from January 5, 1922, to January 8, 1922, that I last saw him alive on January 8, 1922, and that death occurred, on the date stated above, at 1.45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular cardiac disease (aortic (mitral insufficiency) Hypostatic Pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) --- Myocardial insufficiency

(duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinic report.

(Signed) F. N. Gordon, M. D.
Surgeon (R)

, 19 (Address) US. PHS. Hosp. #56 Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment

DATE OF BURIAL 1/10/22

20 UNDERTAKER R C Gross 1405 McCulloh

ADDRESS

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 60143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60143

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH U.S. P.H.S. Hosp. #56, Fort Mc Henry, Balto., Md.

CITY OF BALTIMORE: (No. ..... ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H. Wider

(a) RESIDENCE NO. U.S. P.H.S. Hosp. #56, ST., Balto., Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs E.H. Wider.

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 yrs.	---	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Capt. M.S.

(b) General nature of industry, business, or establishment in which employed (or employer) ------

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant E.T. Rosenbrock(Registrar)

(Address) US. PHS Hosp #56 Balto, Md.

15 Filed ..... 19 Robert P. Harrison, Registrar

01922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1921, to January 9, 1922.

that I last saw him alive on January 9. 1922,

and that death occurred, on the date stated above, at 5:25 P.M.

The CAUSE OF DEATH* was as follows:

Chronic cardiac valvular disease.

Chronic Myocarditis (aortic & mitral regurgitation)

-- (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis) parenchymatous.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -----

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) F. N. Gordon Surgeon (R) M. D.

1/9, 1922 (Address) US. PHS. Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 11 1922

20 UNDERTAKER Peter and Lord — ADDRESS 1733 W Fay Ave

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60144

CERTIFICATE OF DEATH.

X 141

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida Watkins

(a) RESIDENCE. No. 204 Gay St. ST., Cambridge, Md. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of divorced

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife ?

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Elihu Wheatley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elyis Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. Guy Watkins (Address) 2330 N. Linden St

15 Filed JAN 10 1922 19 F E Ellchw Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921, to Jan 10, 1922, that I last saw h.. alive on Jan 10, 1922 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cystocele + rehaffexion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 12-27-1921

Was there an autopsy? no

What test confirmed diagnosis? Clinical course

(Signed) J. W. Twining Jr. M. D.

Jan 10 1922 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Jan 10 1922
20 UNDERTAKER	ADDRESS
H M Routson	228 E Washington

TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 60145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 60145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 East Pratt St., ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Thaman

(a) RESIDENCE NO. 2040 East Pratt St., ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Thaman

6 DATE OF BIRTH (month, day, and year) ----- 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 1 13

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant J. Lewis

(Address) 1411 E. Baltimore St.,

15 Filed 1 01922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10th 19 22

17 I HEREBY CERTIFY, That I attended deceased from Jan 1918, 19—, to Jan. 10, 1922

that I last saw him alive on Jan. 10—, 1922

and that death occurred, on the date stated above, at 10—22 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Chronic. Bronchitis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? ~~Clinical~~ Clinical Signs

(Signed) Wm. H. Magruder, M. D.

, 19 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 1/11 1922

20 UNDERTAKER Jack Lewis 1411 E Balto St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60146

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Road near Calverton Road ST. 70 WARD)

2-FULL NAME Lawrence J. McCormick

(a) RESIDENCE. No. Franklin Road near Calverton Road ST. WARD.
(If nonresident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred 48 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 48 yrs. -- mos -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Delia Johnston

6 DATE OF BIRTH (month, day, and year): April 7, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 082

(b) General nature of industry, business, or establishment in which employed (or employer): Carriage Mfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Lawrence J. McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Furlong

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Miss Theresa M. J. McCormick Franklin Road

15 Filed 1 0 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to Jany 8, 1922, that I last saw him alive on Jany 7, 1922, and that death occurred, on the date stated above, at 7.35 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Carcinoma of Intestines

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. O'Neill M. D.

1/9, 1922 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/11, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60147 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60147

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul S. Fahey.

(a) RESIDENCE. No. 1318 Light ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) DEC 28, 192[illegible]

7 AGE: Years | Months | Days: 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mercy Hosp. Balto, Md

PARENTS

10 NAME OF FATHER Martin Fahey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eva Vieth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Martha F. Fahey (Address) 1318 Light St.

15 Filed Jan 13 1922 Bertha F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from DEC 28, 1921, to Jan 13, 1922, that I last saw h[illegible] alive on Jan 13, 1922, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Premature birth

(6 Months Gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital debility

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms.

(Signed) Dr. [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: 1/16 19[illegible]

20 UNDERTAKER: J. F. Fahey & Son — ADDRESS: 136 Light St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60148

CERTIFICATE OF DEATH.

118-002

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Steward

(a) RESIDENCE. No. 717 Jasper ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Virgie Steward

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer D30

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Fabrick & Brady
(Address) Md Pen

15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January-3 1922

17 I HEREBY CERTIFY, That I attended deceased from December-31 . 1921 . to January-3 . 1922.
that I last saw him alive on January 2 . 1922.
and that death occurred, on the date stated above, at 4.55 a. m.
The CAUSE OF DEATH* was as follows:

Toxemia and Cardiac failure

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William H. Steward, M. D.

1/3 . 1922 (Address) Maryland Penitentiary

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

Commissioner Health.

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

D 60149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60149

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Penitentiary ST. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allen Barbre

(Residence in Baltimore: No. — Lemmert ? St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	~~Wht~~ Cauc.	?

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
38 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer) 087

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Allen

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jailer Dept.

(Address).....

15- Robert F. Harrison,

Filed....., 191.....

N1 01922 Burial Permit Clerk & Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest and autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of chest.

Shot by Ps Dulaney a guard in self defense

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Kelly M. D. (Coroner.)

Dec 22 1921 (Address) 1657 Bl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL JAN 7 1922

18805

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each important. See instructions on back of certificate.

body at city morgue

D 60150 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60150

CERTIFICATE OF DEATH.

182

PLACE OF DEATH

CITY OF BALTIMORE (No. In as much Mission 607 W Saratoga St. H WARD) REGISTERED No. C

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Mayer Edward Mayer

(Residence in Baltimore: No. none except above to my knowledge St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Don't Know

6-DATE OF BIRTH, ... Don't Know, 1 .....
(Month) (Day) (Year)

7-AGE, 60-0-0 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Don't Know

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) none

(Address).....

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

N 10922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 30, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said..... (Inquest, autopsy ~~or inquiry~~) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in chest. Said from accidentally discharged in the hands of some person at this time unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) as above

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D.
(Coroner.)

Jan 4, 1922 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL JAN 1 1922

CAUSE OF DEATH to be plainly written, and all questions answered as far as possible. Every certificate is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 60151

HEALTH DEPARTMENT—CITY OF BALTIMORE

161 001 D 60151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Gutman Ave ST., 9 WARD) (Gibson)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gitlings

(a) RESIDENCE NO. 621 Gutman Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ~~to~~ 1/2 hours. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
Premature Baby			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jos W. Gitlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) 621 Gutman Ave Mother.

15 Filed 1 0 1922 Robert P. Harrison, Registrar

Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 6 1922

17 I HEREBY CERTIFY, That I attended deceased from 1 6, 1922, to 1 6, 1922

that I last saw h.. alive on 1 6, 1922,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Premature (5 months Baby)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Roberts, M. D.

, 19 (Address) 451 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 1 1922 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

per Wm. S. Woolley

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Milton Ave. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Cain

(a) RESIDENCE. No. 507 N Milton Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Cain

6 DATE OF BIRTH (month, day, and year): June 11 - 1848

7 AGE — Years: 73 — Months: 6 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Fireman

(c) Name of employer: Balto City School

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thos Cain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget O'Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant (Address): Jas. Cain 507 N Milton Ave

15 Filed 1922 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1922 to Jan 9 1922

that I last saw him alive on Jan 9 1922

and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows: Cardiac Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemiplegia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Reynolds M. D.

1/9 1922 (Address) 1638 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 1/12 1922

20 UNDERTAKER: Chas Howard & Son — ADDRESS: 1180 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60153

CERTIFICATE OF DEATH.

D 60153

REGISTERED NO. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Price

(a) RESIDENCE No. Unknown St.. Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE. Years	Months	Days	If LESS than 1 day, hrs. or min.
57 ?	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hill Hand 046

(b) General nature of industry, business, or establishment in which employed (or employer) Clipper Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital

15 Filed 1/9/22 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8 1922

17 I HEREBY CERTIFY, That I attended deceased from January 2 1922, to January 8 1922, that I last saw h[illegible] alive on January 7 1922, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 3 yrs mos ds

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs mos 3 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde O'Daniel, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood Cem. Laurel Md. DATE OF BURIAL 1/11 1922

20 UNDERTAKER Chas. F. Evans & Son ADDRESS 118 W. Mt. Royal Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 60154 HEALTH DEPARTMENT—CITY OF BALTIMORE X 20 V D 60154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Plant of the American Sugar Refinery. REGISTERED NO. C

CITY OF BALTIMORE (No. Foot of Stevenson St. ST.: (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas T Lockett.

(Residence in Baltimore: No. 7 Jefferson St. Annapolis, Maryland. St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, August 2nd, 1894., 1 (Month) (Day) (Year)

7-AGE, 27 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Steam Fitter.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 660

9-BIRTHPLACE, (State or Country). Annapolis Md.

PARENTS.

10-NAME OF FATHER Thomas I. Lockett.

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER Mary E. Britton.

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell M. Lockett. (brother).

(Address) 7 Jefferson St. Annapolis Md.

15-

Filed..... 1911 Robert F. Harrison, Registrar.

Burial Permit Clerk.

N 1 01922

CASE OF DEATH in plain terms. Every question must be answered if certificate is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF HEATH.

16-DATE OF DEATH, January 10th, 1922., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Accidentally struck on the head by falling timber.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) /

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... (Coroner) M. D.

Jan. 10th, 1922 (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL. St Anns. Cem. Annapolis Md. DATE OF BURIAL, 1-15 1922

20-UNDERTAKER B. L. Hopping ADDRESS Annapolis Md.

(John J. Byrnes)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60155

CERTIFICATE OF DEATH.

181-001

D 60155

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 239 N. Exeter ST.: 5 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Byrnes

(Residence in Baltimore: No. 25-9 N. Exeter St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	? Divorced?

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 50 about yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Transfer Co

9-BIRTHPLACE, (State or Country), ?

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER .....

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Julia Dept

(Address) .....

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

1 0192

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia due to accidental Gas poisoning

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jan 10, 1922 (Address) 1634 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincents Cem

DATE OF BURIAL, Jan 11th, 1922

20-UNDERTAKER Robert S Buchanan

ADDRESS CALHOUN & HOLLINS ST

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60156

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Weber. Duncan

(a) RESIDENCE. No. 915 N. Linton St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mary Weber.

6 DATE OF BIRTH (month, day, and year) March 19 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57.	9.	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Weber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Hospital Records (Address)

15 Filed . 19 Robert P. Harrison, Registrar

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 12. 1921, to Jan. 8, 1922

that I last saw him alive on Jan 8, 1922

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos. 39 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema (duration) yrs. mos. 8 hrs

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys Signs

(Signed) D. J. Sullivan M. D.

. 19 (Address) Mercy Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 12 1922
20 UNDERTAKER	ADDRESS
Wm L. Miller	2334 Jefferson St

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks. — William - Cole

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60157

CERTIFICATE OF DEATH.

100-00! D 60157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 716 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cole

(a) RESIDENCE. No. Unknown St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nelson Co., Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JAN 11 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from January 5, 1922, to January 6, 1922, that I last saw him alive on January 5, 1922, and that death occurred, on the date stated above, at 8:15 A. M.

The CAUSE OF DEATH* was as follows:

Peritonitis (Coll)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

1/6/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 11 1922
20 UNDERTAKER	ADDRESS
Clement Hall	909 Fulton St

CAUSE OF DEATH must be stated plainly. Use no abbreviations or ditto marks. Make no use of terms like "Heart Failure," "Exhaustion," "Blood Poisoning," "Septicemia," "Pneumonia," "Cancer," "Tumor," "Stroke," "Fever," "Cold," "Grippe," "Influenza," "Meningitis," "Hemorrhage," "Convulsions," "Paralysis," "Uremia," "Jaundice," "Abscess," "Debility," "Old Age," "Infection," "Malignant Disease," or "Childbirth," without stating the cause on which each depends. IF DEATH WAS DUE TO EXTERNAL CAUSES, state how injury occurred, whether accidental, suicidal, or homicidal. This information is required in all cases whether or not a coroner's inquest is held. See instructions on back of certificates. TION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons employed in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Streptococcus Pneumonia

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60158

HEALTH DEPARTMENT—CITY OF BALTIMORE

179

D 60158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1701 Fawcett St.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza A. Gempp.

(a) RESIDENCE. No. 1701 Fawcett ST., 16 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick M. Gempp.

6 DATE OF BIRTH (month, day, and year) Mar 1-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Josiah T. Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Schuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Frederick M. Gempp

(Address) 1701 Fawcett St.

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1921, to Jan 8, 1922, that I last saw h[illegible] alive on Jan 8, 1922, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Fibroid growth in abdomen (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E Cuchman, M. D.

(Address) 2232 E Fenington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	July 11 1922

20 UNDERTAKER John Studio 1200 E. Fairmount ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood by persons in all parts of the country. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Benign tumor.
Chr Nephritis

D 60159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 C 001

D 60159

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1103 W Lombard ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John P. McGuire

(Residence in Baltimore: No. 1103 W Lombard St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, April (Month) 30 (Day), 1880 (Year)

7-AGE. 41 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce dealer 045
(b) General nature of industry, business, or establishment in which employed (or employer): for himself

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter McGuire

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Young

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth McGuire

(Address) 1103 W Lombard St

15-

Filed JAN 11 1922, 191.... Registrar.

ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiation by illuminating gas accidental, gas stove Improperly fitted by plumber (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Had been living in gas heated & lighted room (Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

Jan 9, 1922 (Address) 710 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? 1103 W Lombard St

Former or usual residence 1103 W Lombard St

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Jan 11, 1922

20-UNDERTAKER John Hurle — ADDRESS 1205 W Lombard

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60160

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3625 Chestnut Ave St. 13 WARD)

2-FULL NAME Jennie S Ford

(a) RESIDENCE. No. 3625 Chestnut Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Archibald C Ford

6 DATE OF BIRTH (month, day, and year) Jan 10 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George W Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary S Burk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Archibald C Ford
(Address) 3625 Chestnut Ave

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1922

17 I HEREBY CERTIFY, That I attended deceased from March, 1919, to Jan. 8, 1922, that I last saw her alive on Jan. 8, 1922, and that death occurred, on the date stated above, at 1-50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) A.W. Smith, M. D.

19 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jan 11 1922

20 UNDERTAKER Ehrenwerth & Son ADDRESS Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60161

CERTIFICATE OF DEATH.

74-001 D 60161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 413 S Clinton ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Woehner

(a) RESIDENCE. No. 413 S Clinton ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of John Woehner

6 DATE OF BIRTH (month, day, and year) March 23 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Werrlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John G Woehner
(Address) 413 S Clinton St

15 Filed JAN 11 1922 ROBERT R. KRAUSE, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/22 19

17 I HEREBY CERTIFY, That I attended deceased from 1/1/22, 19..., to 1/9/22, 19...,
that I last saw h[illegible] alive on 1/9/22, 19...,
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Myocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Bowman, M. D.

1/11 1922 (Address) 2919 Walbrook

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	1/12 1922
20 UNDERTAKER	ADDRESS
Louis Heemann	324 Druid Hill Ave

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 60162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60162

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Simonton

(a) RESIDENCE NO. 1647 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 0 Months 0 Days 0 If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Simonton

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Eliza Archer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) Johns Hopkins Hospital

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 19 22

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 19 22, to Jan 6, 19 22,

that I last saw him alive on Jan 6, 19 22

and that death occurred, on the date stated above, at 3.00 p m.

The CAUSE OF DEATH* was as follows:

Atelectasis

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. H. Cattrall M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 10 1922 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Do not use abbreviations or technical terms. Omission to answer any question will delay burial. Physician should fill out statistical particulars and medical certificate of death. Undertaker should fill out all other particulars. Certificate should be filled out in full by person in charge of case after death or removal from house. Information should be given by person best informed as to the facts. Write plainly with pen and ink. Use figures in stating ages, dates, and addresses. Sign full name. Do not abbreviate. Fill every blank for which you have the information. If you cannot answer a question, say so. Do not guess. Every certificate must be complete and correct. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60163

CERTIFICATE OF DEATH.

74-09 D 60163

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 N. Vincent ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Rebecca Nelson

(a) RESIDENCE. NO. 17 N. Vincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced (or) WIFE of Clayton Nelson

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer Private families West Pitts Mass.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Walter Nelson (Address) 17 N. Vincent Ave

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3 , 1922, to Jan. 8 , 1922, that I last saw h[illegible] alive on Jan. 7 , 1922, and that death occurred, on the date stated above, at 12:25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. Lee Cooley, M. D.

, 19 (Address) 406 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan. 1 , 19

20 UNDERTAKER A. Jones ADDRESS 217 S. Stricker St

CAUSE OF DEATH to be plain terms, so that [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60164

99 D 60164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 748 Reservoir St. (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Higgins

(a) RESIDENCE. No. 748 Reservoir St. ST., 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rebecca J. Higgins

6 DATE OF BIRTH (month, day, and year) Apr. 30, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mont. Co. Md.

PARENTS

10 NAME OF FATHER Jesse T. Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jessie Higgins
(Address) 608 Eaton Ave.

15 Filed JAN 11 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9/22

17 I HEREBY CERTIFY, That I attended deceased from Jan 1-22, to Jan 9-22,
that I last saw h[illegible] alive on Jan 8/22,
and that death occurred, on the date stated above, at 8.30 P.M.
The CAUSE OF DEATH* was as follows:

Tracheo-Bronchitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

Sudden (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) D. E. Frank MD. M. D.

19 (Address) 1929 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1/11 '22

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60165

CERTIFICATE OF DEATH.

90 60165

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 123 S. Chester St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Jenner

(a) RESIDENCE. NO. 123 S. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Jenner

6 DATE OF BIRTH (month, day, and year) May 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hw.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Sam Jacob Hanskin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rose Leon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Max Jenner 2100 E. Eager St

15 Filed JAN 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from ~~Jan~~ March, 1920, to Jan. 11, 1922, that I last saw her alive on Jan. 11, 1922, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis with Arteriosclerosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Cancer~~ Cerebral Embolism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Israel J. Feinglass M. D.

, 19 (Address) 2007 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Sholom	Jan 11 1922

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. Information required by this certificate is necessary for the legal protection of the family and for the compilation of accurate statistics. Information required by this certificate is necessary for the legal protection of the family and for the compilation of accurate statistics. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 392 Kate Ave ST.; 15 WARD)

REGISTERED No. C 101 .001 D 60166

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Frances Bishop

(Residence in Baltimore: No. 392 Kate ave Forest Park St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH Jan 4 (Month) (Day), 1852 (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Annapolis Md

PARENTS.

10-NAME OF FATHER, William Jewell

11-BIRTHPLACE OF FATHER (State or Country) Annapolis Md

12-MAIDEN NAME OF MOTHER Margaret F Jewell

13-BIRTHPLACE OF MOTHER (State or Country) Annapolis

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel L Bishop

(Address) 392 Kate Ave

15- Filed JAN 11 1922, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7 (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 1922, to Jan 10 1922

that I saw her alive on Jan 9 1922,

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. C. Metcalf M. D.

Jan 10, 1922 (Address) 190 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Jan 13 1922

20-UNDERTAKER George J Smith — ADDRESS 1008 Fayette E

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 205 Goodwood Gardens (Roland Park WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Reeder Lanahan

(a) RESIDENCE. No. 205 Goodwood Gardens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced (write the word)~~: Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Samuel J Lanahan

6 DATE OF BIRTH (month, day, and year): Oct 10- 1847

7 AGE: Years 74 Months 3 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Reeder.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Ann Sherlock.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: W. Wallace Lanahan
(Address): Calvert Bldg.

15 Filed JAN 11 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from October 26th 1921, to January 10th 1922, that I last saw h[er] alive on January 9th 1922, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary): Angina Pectoris

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Reuben F. Steinman, M. D.

19 (Address) 1227 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	1-12 1922

20 UNDERTAKER: Herring & Jenkins Funeral Co

ADDRESS: 701 Cathedral St

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 ✓ D 60168

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1020 - Linden Ave (St.:) 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rebecca W. Hughes

(a) RESIDENCE. No. 1020 Linden ave (Confederate Womans Home) (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): 1839 Feb 22

7 AGE: Years 82 | Months 10 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

807

9 BIRTHPLACE (city or town) (State or country): Culpeper County Va

PARENTS

10 NAME OF FATHER: Thomas Grady

11 BIRTHPLACE OF FATHER (city or town) (State or country): Culpeper Va

12 MAIDEN NAME OF MOTHER: Sallie Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fredericksburg Va

14 Informant: Mrs C. P. Dutrow

(Address): 1862 - Mintwood Pl.

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 1915, to Jan. 9th, 1922, that I last saw h.r. alive on Jan 9th, 1922, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumen in urine

(Signed) Henry E. Gale, M. D.

, 19 (Address) ~~1160~~ E. W. Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: 1-11-1922

20 UNDERTAKER: Henry W. Jenkins & Son Co

ADDRESS: Orchard & Caroline Sts

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60169

CERTIFICATE OF DEATH.

129 D 60169

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Rutland Ave. St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Gray.

(a) RESIDENCE. No. 1812 Rutland Ave St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ellen Gray

6 DATE OF BIRTH (month, day, and year) July 22 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Carpentry & Building

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ellen Gray
(Address) 1812 Rutland Ave

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 21 1921 to Jan 10 1922.

that I last saw him alive on Jan 10 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senile pulmonary Edema

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Analysis

(Signed) [illegible] M. D.

1/11. 1922 (Address) Maple Ave - Belair Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Back Cemetery Gra	May 14 1922
20 UNDERTAKER	ADDRESS
[illegible] Turner	N. Bond St

CAUSE OF DEATH in plain terms. Indefinite answers such as "Heart Failure," "Old Age," "Senility," "Exhaustion," "Convulsions," "Uremia," "Cancer," "Tumor," are not sufficient. If from violence, state MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. If a woman, state whether pregnant, recently confined, or abortion. If from disease of specific organ, state which. If from contagious disease, state name. If from any disease peculiar to children, state age in months, days or hours. If from old age, state exact age in years, months and days. If from occupation, state nature of occupation and number of years employed therein. If from accident, state when and where occurred. If from suicide, state reason, if known. If from homicide, state name of criminal, if known. If from any cause except disease, state cause. If from disease, state cause, if known, as well as disease. If from more than one cause, state all causes, primary, secondary, contributory, and order of sequence. If from disease, state duration of each. If from operation, state nature of operation, date, and name of operating physician. If from typhoid fever, state whether any typhoid fever prevailed in locality or house during month preceding date of onset. If from tuberculosis, state whether sputum examined, and with what results. If from cancer, state whether confirmed by microscopic examination. If from violence, state whether injury was received in mine, factory, railroad, or other industry, and whether while employee was at work. If from poisoning, state name of poison, whether taken accidentally or with suicidal or homicidal intent, and whether prescribed by physician. If from drowning, state whether body has been found. If from burns, state whether conflagration, explosion, or burning clothing. If from starvation, state whether complicated with alcoholism, and whether there was neglect. If from execution, state whether sentence was just. If from any cause not specified above, state fully and specifically how it arose. If unknown, state whether deceased was seen after death by physician, coroner, or other person, and when.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60170

D 60170

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 822 So. Luzerine Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kathryn Lisek

(Residence in Baltimore: No. 822 S. Luzerine Ave St.; 74 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female,	White,	Married,

6-DATE OF BIRTH, Unknown, ... (Month) ....., 1 ..... (Day) (Year)

7-AGE, ... 75 ..... yrs. ..... 0 ..... mos. ..... 0 ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None, 637

9-BIRTHPLACE, (State or Country), Poland,

PARENTS.

10-NAME OF FATHER, Unknown,

11-BIRTHPLACE OF FATHER (State or Country), Poland,

12-MAIDEN NAME OF MOTHER Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Katherine Kiecal, (Duchter)

(Address) ..... 822 So. Luzurine Ave

15- Filed JAN 11 1922, 191... ROBERT R. KRAUTER, Deputy Permit Clerk. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan ..... (Month) ..... 9 ..... (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1918 ~~191~~, to Jan 9 1922, that I saw h[illegible] alive on Jan 9 1922, and that death occurred, on the date stated above, at 11 30 p.m.

The CAUSE OF DEATH* was as follows:

..... Apoplexy .....

..... (Duration) ..... 3 yrs. ..... 3 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Arteriosclerosis .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Frank A. Simpson M. D.

Jan 9..., 1922 (Address) ..... 2481 Fait Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
ST. STANISLAUS CEMETERY	Jany 12, 1922

20-UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Ann St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60171

D 60171

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH 907 N. Carrollton Ave. REGISTERED NO.....

CITY OF BALTIMORE: NO. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Elizabeth Eichholtz.

(a) RESIDENCE. NO. 907 N. Carrollton Ave, WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry C. Eichholtz

6 DATE OF BIRTH (month, day, and year) Dec 16 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER James Todd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Mc Gotty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Miss Emma Eichholtz
(Address) 907 N Carrollton

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from January 5th, 1922, to Jan. 9th, 1922, that I last saw h.. alive on 9 AM-Jan 9th, 1922, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy with Right Hemiplegia & Aphasia,

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Senile degenerations Factors,

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? No,

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Wilmer Brinton, M. D.

, 19 (Address) 1. W. Cor. Calvert & Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 12 1922

20 UNDERTAKER W. W. Coulson

ADDRESS 2235 W Baltimore

CAUSE OF DEATH in plain terms. Omissions or indefinite statements cannot be accepted. Certificate must be filled out in full. See instructions on back of certificates. TION is very important. See instructions

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60172

CERTIFICATE OF DEATH.

164 D 60172

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1824 N. Exeter ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Boudrie

(a) RESIDENCE. NO. 1824 N. Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moore R. Boudrie

6 DATE OF BIRTH (month, day, and year) Feb 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	+		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Same address

15 Filed JAN 11 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Jan 9th 1922, that I last saw h[illegible] alive on Jan 9th 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Chas. E. Ellwood M. D.

Jan 11 1922 (Address) 425 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 12 1922
20 UNDERTAKER	ADDRESS
Johannes Sanders	946 Aisquith St

CAUSE OF DEATH must be given. See instructions on back of certificates. THIS is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60173

CERTIFICATE OF DEATH.

49 D 60173

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Eastland Ave ST.: 7 WARD)

2-FULL NAME Frank J. Enach

(a) RESIDENCE. No. 1904 Eastland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Enach

6 DATE OF BIRTH (month, day, and year) Feb 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Enach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Korbawer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Lenore E. M. Enach
(Address) 1906 Eastland Ave

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7. 1921, to Jan 9, 1922, that I last saw h[illegible] alive on Jan 9, 1922 and that death occurred, on the date stated above, at 7.20 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Bladder

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J. Powers, M. D.

(Address) Jan 10, 22 801 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 12 1922
20 UNDERTAKER	ADDRESS
Chas. Schaffer	E Monument

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 60174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Highland Ave ST.; 26 WARD)

2-FULL NAME Elizabeth Cerny

(a) RESIDENCE. NO. 111 N. Highland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Office Help
(b) General nature of industry, business, or establishment in which employed (or employer): 004
(c) Name of employer: Md City Garage

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph Cerny

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Mary Wallbens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Mary Beckenzty
(Address): 111 N. Highland Ave

15 DATE RECEIVED JAN 11 1922 ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1921 to Jan 10th 1922
that I last saw h alive on Jan 10th 1922
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

Asc. Pulm Edema & Myocarditis
(duration) Pulm TB 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright L. Snyder M. D.
Jan 1922 (Address) 3323 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 13 1922
20 UNDERTAKER	ADDRESS
Fred Evers Son	906 Gilmor

TION is very important. See instructions on back of
ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60175

CERTIFICATE OF DEATH.

38

D 60175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 160 W. West St. 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Rush

(a) RESIDENCE. No. 160 W. West St. 23 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic NO

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Clinton Barksdale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Julia Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Charles Barksdale

(Address): 160 W. West St

15 Filed JAN 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/1922

17 I HEREBY CERTIFY, That I attended deceased from 1/27/21 to 1/9/22, that I last saw her alive on 1/9/22 and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis OVER

about (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Aneurism of Carotid

about (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas Brooke M. D.

1/10/1922 (Address) 908 D Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn et — DATE OF BURIAL: Jan 12 1922

20 UNDERTAKER: J. F. Elworth & Son — ADDRESS: 707 W. Monty

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic infection.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 60176

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Joyner

(a) RESIDENCE. NO. 147 Montgomery St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital records, Municipal Hospital.

15 Filed JAN 11 1922, 19 ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from December 23 1921, to January 8, 1922, that I last saw her alive on January 8, 1922, and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde M. Neill, M. D.

1/9/, 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 12 1922

20 UNDERTAKER	ADDRESS
J. L. Brown & Son	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60177

D 60177

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Boyview Hospital

CITY OF BALTIMORE: (No. ... St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Phoenix

(a) RESIDENCE. No. 406 N. Hunting St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Tom Phoenix

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Boyview Hospital Balto. Md.

15 Filed ... 19 ROBERT R. KRAUTER, Registrar

JAN 11 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 9. 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1921. to Jan 9. 1922

that I last saw h alive on Jan 8 1922

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebro Spinal Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cuba

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Serological

(Signed) H. F. Downes M. D.

1/10/1922 (Address) Boyview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	Jan 12 1922

20 UNDERTAKER: L. L. Brown's Son — ADDRESS: 101 N Monty

TION is very important. See instructions on back of certificates.

Misc.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60178 D 60178

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Md Gentrapt ST.: 27 WARD)

2-FULL NAME Casimire Labanvckas

(a) RESIDENCE. NO. 218 Shutaw St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 2, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rustin 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Quelos Labanvckas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Kircait

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Castantas Labanavskas
(Address) 703 W Lomberd St.

15 Filed JAN 11 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/7/22, 19, to 1/9/22, 19, that I last saw h alive on ~~9/10~~ 1/9/22, 19, and that death occurred, on the date stated above, at 9 25P m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Muscular Rheumatism

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms

(Signed) Autopsied, M. D.

, 19 (Address) Mt Sinai Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Janv 13 1922
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca

CAUSES OF DEATH. Please read carefully the physician's instructions on back of certificates. ATTENTION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60179

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 222 E Chase ST.: 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie R Werner

(Residence in Baltimore: No. 222 E Chase St.: 32 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Apr. 18, 1879
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md Co Md

PARENTS.

10-NAME OF FATHER, Thomas R Cromwell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna C. Mackin

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Werner

(Address) 222 E Chase St

15-

Filed ....., 191.....

Robert P. Harrison
Registrar.

Burial Permit Clerk.

JAN 1 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1921, to Jan 10th 1922, that I saw h[illegible] alive on Jan 10th 1922, and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease & Nephritis

Personal History (Duration) 3 yrs. 3 mos. ds.

(Signed) Henry D Holland M. D.

Jan 10th, 1922 (Address) 1203 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	1/12, 1922
20-UNDERTAKER	ADDRESS
E J Fanning	1260 Eutaw

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 60180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60180

CERTIFICATE OF DEATH.

X 117

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Griffin

(a) RESIDENCE. No. 246 East 22nd (66) ST., WARD. Erie, Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occu... mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~or WIFE of~~ Henrietta Griffin

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	3	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John Edward Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Howells.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Griffin
(Address) 1807 McCulloh

15 Filed Robert P. Harrison
Registrar
1922
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922, to Jan 10, 1922
that I last saw him alive on Jan. 10, 1922.
and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? Yes (Date of Jan 3, 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W. Whitehead, M. D.

(Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	1/12 1922
20 UNDERTAKER	ADDRESS
I. Frew McCully	130 E. Fort

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60181

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH South Balto. General Hospital

CITY OF BALTIMORE: (No. ..... ST.: 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Carr

(a) RESIDENCE. No. 1502 Park Terrace Locust Point ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18. 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Agnes Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Mrs. Carr 1502 Latrobe Ter.

15 Filed Robert [illegible] Registrar

1 1 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30 1921, to Jan. 10, 1922.

that I last saw him alive on Jan. 10, 1922.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Intestional obstruction

(duration) yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Jan. 10, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Carl F. Benson, M. D.

, 19 (Address) South Balto. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	1/13-22 19
20 UNDERTAKER J. F. McCully	ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) ST.: 2 WARD: 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Colin Mac Donald

(a) RESIDENCE. No. 802 S. Broadway ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-21-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Roland Mc Donald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Annie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address)

15 Filed 1-11-1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-14, 1921, to 1-6, 1922,

that I last saw h[illegible] alive on 1-6, 1922,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Peritonitis with multiple encysted abscesses.

Empyema, left, Pyelitis left

(duration) several months?

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 11-30-21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Culture Chest fl[illegible]

(Signed) Julian D Hirst, M. D.

, 19 (Address) Johns Hopkins Hosp. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

For Wm. R. WOODAL[illegible]

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60183 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60183

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Davidson

(a) RESIDENCE. No. None ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital JOHNS HOPKINS HOSPITAL

15 Filed 1/11/22 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7 1922

17

I HEREBY CERTIFY, That I attended deceased from January 7, 1922, to January 7, 1922, that I last saw her alive on January 7, 1922, and that death occurred, on the date stated above, at 10 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

Autopsy (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

Autopsy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) L. H. Brumbold, M. D.

1/9/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH. See instructions on back of certificates. IMPORTANT is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60184

CERTIFICATE OF DEATH.

REGISTERED No. C 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2632 Fruby ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Gildenfenny

(Residence in Baltimore: No. 2632 Fruby St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH ..... January (Month) 12 (Day), 1877 (Year)

7-AGE, 44 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore - Md.

PARENTS.

10-NAME OF FATHER, Charles J. Gildenfenny

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia - Penna

12-MAIDEN NAME OF MOTHER Maria Ward

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles J. Gildenfenny

(Address) 2632 Fruby St.

15- Filed ....., 191.... Robert P. Harrison, Registrar.

JAN 1 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 8 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20 1921, to January 8 1922, that I saw him alive on January 3 1922, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of cervical glands left side

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(Duration) 1 yrs. mos. ds.

(Signed) Butler E. Lapman M. D.

Jan. 9, 1922 (Address) 2733 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
New Cathedral	1/12, 1922
20-UNDERTAKER	ADDRESS
H. Russelburg	2620 St Paul

important. See instructions on back of certificate.

D 60185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60185

CERTIFICATE OF DEATH.

178 ✓

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1208 Wilcox E. ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josefine Platen

(Residence in Baltimore: No. 1208 Wilcox St.

St.: yrs. 75 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED: (Write the word.) Widow

6-DATE OF BIRTH: Aug 30, (Month) (Day) 1845 (Year)

7-AGE: 75 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: John Stemmer

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Gertrude Miller

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Stemmer

(Address) 2141 Wilkens Ave

15- Robert P. Harrison,

Filed ..... 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan 10, (Month) (Day) 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns face arms & legs

Origin unknown

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Kirk Gurley M. D.
(Coroner.)

1-17-12 191.... (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL: Balto Cemetery

DATE OF BURIAL, Jan. 12, 1912

20-UNDERTAKER: George L Schnaf

ADDRESS 3101 Gud[illegible] Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60186

CERTIFICATE OF DEATH.

D 60186

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Violet Ave (ST.) near Williams ave (WARD) 7

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Joh

(a) RESIDENCE. No. Violet Ave (ST.) Wittmore Ave near Williams ave (WARD)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sallie V. Joh

6 DATE OF BIRTH (month, day, and year): Apr. 5 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer): For self

(c) Name of employer: Balto. Md

9 BIRTHPLACE (city or town) (State or country): Adam Joh

PARENTS

10 NAME OF FATHER: Adam Joh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Hanser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lewis Joh (Address) Violet Ave & Wittmore Ave Balto City

15 Filed Robert F. Garrison, Registrar

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1922, to Jan 9, 1922, that I last saw h[illegible] alive on Jan 9, 1922, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Degeneration

(duration) yr. 0 mos. 1 ds.

CONTRIBUTORY (Secondary): Aortic Regurgitation

(duration) yrs. [illegible] mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

Jan 11 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Jan 12 1922
20 UNDERTAKER	ADDRESS
Geo. L. Schwab	2101 Eutaw MC

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of DEATH is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60187

D 60187

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 E. Hamburg ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andw. H. Borchersding

(Residence in Baltimore: No. 40 E. Hamburg. St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 6 (Day), 1863 (Year)

7-AGE, 38 yrs. 7 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Herman Borchersding

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Lucinda Baetz Feder

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Borchersding

(Address) 40 E. Hamburg

15-

Filed....., 191.....

Robert F. Harrison,
1922 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1922, to Jan. 9 1922, that I saw h[illegible] alive on Jan. 9 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Wells Anders M. D.

Jan. 10, 1922 (Address) 423 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Jan. 12, 1922

20-UNDERTAKER F. A. Kramer & Son

ADDRESS 703 Hanover

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificate.

(Mc Aleer)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60188

D 60188

CERTIFICATE OF DEATH.

178

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) St Joes Hospital ST. 10 WARD)
2-FULL NAME Lady Mc Aleer.
(Residence in Baltimore: No. 1206 Wilcox.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 22 years mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Wht	Sing.

6-DATE OF BIRTH, ... (Month) ....., 1 ..... (Day) (Year)

7-AGE, 37 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Slag Roofer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Nicholas McAleer
11-BIRTHPLACE OF FATHER (State or Country), Irrland
12-MAIDEN NAME OF MOTHER Bridgt Gorman
13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James McAleer
(Address) 2[illegible] N. E. Boulevard

15- Robert [illegible]
[illegible], 191.....
JUN 11 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June 10 ....., 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Larynx
Upon for a Duration of 1208 Wilcox St
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
(Coroner)
June 12, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem
DATE OF BURIAL, June 12, 1922
20-UNDERTAKER Walter Davis
ADDRESS 3307 Fairmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST.: 1st WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Albert Wm. Hayden Thompson

(a) RESIDENCE. No. 828 De Grasse Ave ST., WARD. Newark N. J.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White, American	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B. Thompson

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of Industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn. R. I.

PARENTS

10 NAME OF FATHER Horace Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER S. Louise Sweet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) R. I.

14 Informant (Address) Mary V. Thompson Newark N.J.

15 Filed Robert P. Harrison Registrar

N 1 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to Jan 10, 1922, that I last saw h[illegible] alive on Jan 10, 1922, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, bilateral.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George E. W. Hardy M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newark N. J.	Jan 12 1922

20 UNDERTAKER John O. Mitchell ADDRESS 201 N. Bayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

Spec. 1-9-19—H. P. Co.—1000 Blks.

13795

D 60190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57 D 60190

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 7 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hall

(a) RESIDENCE. No. 315 Mt. Pleasant St. ST.,
(Usual place of abode) N.W. Washington D.C.

WARD. Washington D.C.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Hall

6 DATE OF BIRTH (month, day, and year): Nov. 7th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Silas L Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliz. Whittaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant (Address):

15 Filed . 19 Registrar

N1 1 1922

Robert F. Harrison
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-19 . 1921 . to 1-11 . 1922

that I last saw h[illegible] alive on 1-11 . 1922.

and that death occurred, on the date stated above, at 5 05 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Catarrhal Jaundice

(duration) — yrs. — mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L Dorsey, M. D.

, 19 (Address) I. H. H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Jany 12 1922

20 UNDERTAKER	ADDRESS
John O. Mitchell	120 N. Fayette

mation should be entered, supplying, so that it may be properly classified. Exact statement of DISEASES CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASES TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 D 60191

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1837 Harford Ave (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Saunders

(a) RESIDENCE. No. 1837 Harford Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Saunders

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 64 | Months 3 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrical Linesman

(b) General nature of industry, business, or establishment in which employed (or employer): Mechanical

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Edward Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Leighton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Fannie Saunder German Hill Road

15 Filed JAN 11 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24 1921 to Jan 1 1922

that I last saw him alive on Jan 1 1922

and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Nephritis, (Parenchymatous)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. one mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms Microscopic Examination

(Signed) H. H. Kinder M. D.

19 (Address) 2300 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Jan 12th 1922

20 UNDERTAKER: Leo G. Cook — ADDRESS: Northwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60192

CERTIFICATE OF DEATH.

164 D 60192

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 78 S. Regester ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hart

(a) RESIDENCE. NO. 78 S. Regester ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Amelia Hart

6 DATE OF BIRTH (month, day, and year) May 1 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dietrich Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dietrich Kuder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Hart (Address) 78 S. Regester St

15 Filed JAN 11 1922 19 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922 to June 10, 1922

that I last saw h... alive on January 9, 1922

and that death occurred, on the date stated above, at 1550 P. m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Old age

(duration) 12 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. Fiedler, M. D.

June, 1922 (Address) 1802 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cemetery	Jan. 13 1922
20 UNDERTAKER	ADDRESS
Wendel & Geppel's Son	37 S. Carey St

Information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60193

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 60193

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Albert T. Luber

(a) RESIDENCE. NO. 1939 Christian St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	--	--	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Laurel, Maryland

PARENTS

10 NAME OF FATHER: Joseph Luber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant: Hospital Records,
(Address): Municipal Hospital.

15 Filed Jan 11 1922 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from December 27 1921. to January 9. 1922.
that I last saw him alive on January 9 . 1922.
and that death occurred, on the date stated above, at 6:05 P.M.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. O'Neill, M. D.

1/10/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Joy Hill Cemetery, Laurel Md.	Jan 12

20 UNDERTAKER: Harry H. Witzke ADDRESS: 5314 W. Lombard St.

MAIL SHOWING IN ALL CASES CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

60194

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

179 D 60194

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle A Peters

(Residence in Baltimore: No. 1222 Oakhurst Pl St.: yrs. 4 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, Nov 6, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John B. Peters

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER Mary J. Rowe

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John B. Peters

(Address) 1222 Oakhurst Pl

15-

Filed....., 192.. ROBERT R. KRAUTER, Registrar.

JAN 12 1922 Burial Permit C...

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

29 Burns over body, body by Gas Explosion Accident from Gas Stove

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Bruce M. D. (Coroner.)

Jan 11, 1922 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1222 Oakhurst Pl

Former or usual residence 1222 Oakhurst Pl

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	1-12, 1922
20-UNDERTAKER Earl B Hale	ADDRESS 115 E Lexington St

CAUSE OF DEATH in ... so that it may be properly classified. ... important. See instructions ... of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-60195 D 60195

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH CITY OF BALTIMORE: (No. 1528 Byrd St. (Ward)) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence E. Thomas

(Residence in Baltimore: No. 1528 Byrd, St.; ..... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX ~~Male~~

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 1 (Month) 11 (Day), 1922 (Year)

7-AGE, ... yrs. Three mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo E Thomas

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co

12-MAIDEN NAME OF MOTHER Louise E Gamble

13-BIRTHPLACE OF MOTHER (State or Country) Cambridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo E Thomas

(Address) 1528 Byrd St

15-

Filed ....., 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

JAN 12 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 11 (Day), 1922. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/11 1922, to 1/11 1922, that I saw h his alive on 1/11 1922, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Dyspnoea

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gen Weakness

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. G. Brockington Jr. M. D.

....., 101... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Jan. 12, 1922.

20-UNDERTAKER William Lack — ADDRESS 502 E North Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60196

CERTIFICATE OF DEATH.

1471 D 60196

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella R. Duffy

(a) RESIDENCE. NO. 2807 Greenmount Ave ST.; ..... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William P Duffy

6 DATE OF BIRTH (month, day, and year) Oct 10 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo R.V. Dilehunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helena Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Husband.
(Address) 2807 Greenmount Ave

Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/6/ 1922, to 1/12/ 1922
that I last saw her alive on 1/12/ 1922
and that death occurred, on the date stated above, at 6-15 a m.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Illeus
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1/7/22

Was there an autopsy? No

What test confirmed diagnosis? P. S. + Symptoms.

(Signed) Hugh Brent M. D.

. 19 (Address) 16 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral —	1-16 1922
20 UNDERTAKER James Dignan & Son 1000 E Pres St	ADDRESS

CAUSE OF DEATH must be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60197

CERTIFICATE OF DEATH.

1 29 D 60197

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 N. Hope ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Tingling

(a) RESIDENCE NO. 1902 N. Hope ST., 9 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late John Tingling

6 DATE OF BIRTH (month, day, and year) May 14 1851

7 AGE	Years	Months	Days	If LESS than 1 day ...hrs or ...min
	70 Years	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Evans.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Evans.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Elmer Robinson

(Address) 1902 Hope st.

15 Filed JAN 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from

Nov 10, 1921, to Jan 9, 1922

that I last saw her alive on Jan 9, 1922,

and that death occurred, on the date stated above, at 4 30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John O Arey, M. D.

, 19 (Address) 1603 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Jan 12 1922

20 UNDERTAKER George J. Ruth

ADDRESS 1235 Hayford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60198 90 D 60198

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2705 Boone ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Sapp

(a) RESIDENCE. No. 2705 Boone ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Sapp

6 DATE OF BIRTH (month, day, and year) Dec 31 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sash Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Sapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Joseph W. Sapp (Address) 2705 Boone St

15 Filed JAN 12 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) January 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Jan 10 1922, that I last saw h alive on Jan 10 1922, and that death occurred, on the date stated above, at 11 G m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. W. Long M. D.

1/10, 1922 (Address) 4426 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 12 1922

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. Fayette Ave

CAUSE OF DEATH to be filled in plain terms. So that a medical man can understand it. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60199

CERTIFICATE OF DEATH.

135

D60199

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 70 ST.; WARD)

2-FULL NAME Evan B. Chaney

(a) RESIDENCE. No. 1935 W. Lexington St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-17-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 909

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Enoch Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ? Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant
(Address)

15 Filed JAN 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10 1922.

17 I HEREBY CERTIFY, That I attended deceased from 2-8 1921, to 1-10 1922,
that I last saw him alive on 1-10 1922,
and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:
General Peritonitis (Purulent + fibrinous)
Bilateral Pyelitis, Perineal Abscess, Rt.
Cystitis, Broncho Pneumonia, (Terminal)

(duration) Patient's [illegible] mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. [illegible] mos. [illegible] ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Aug 1920 12-16-21

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Julian D. Hett, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friendship A.M.E.	Jan 13 1922
20 UNDERTAKER Robert L. Steele	ADDRESS 1702 Edmondson Ave

CAUSE OF DEATH in plain terms, so that a stranger can understand. See instructions on back of certificates.
TION is very important.

Form 6-9-19 H. P. Co.—1000 Bks.

D 59270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60200

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Turner

(a) RESIDENCE. NO. 51 E. Dukes ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster shucker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sophie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant
(Address)

15 Filed JAN 12 1922 19 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5th, 1922, to Jan. 9th, 1922.

that I last saw h~~m~~alive on Jan. 9th, 1922.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

About 10 yrs. ~ mos. ~ ds.
(duration)

CONTRIBUTORY (Secondary) Pneumothorax (Spontaneous)
(duration) ~ yrs. ~ mos. 9 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ~

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray, Sputum Exam.

(Signed) Francis R Dieuaide, M. D.

Jan. 10, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	1/12/22 19
20 UNDERTAKER J R L Parham	ADDRESS 649 W. Lee st

CAUSE OF DEATH should be plainly written. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60201

CERTIFICATE OF DEATH.

44 D 60201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 84 Harlem Ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William August Rock

(a) RESIDENCE NO. 84 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Rock

6 DATE OF BIRTH (month, day, and year) Oct 17 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture 045

(b) General nature of industry, business, or establishment in which employed (or employer) Maker

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augusta Rock (Address) 84 Harlem Ave

15 Filed JAN 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1922

17

I HEREBY CERTIFY, That I attended deceased from May 30. 1921, to Jan 11. 1922, that I last saw h[illegible] alive on Jan 10. 1922 and that death occurred, on the date stated above, at 12-15 9 m.

The CAUSE OF DEATH* was as follows:

OTEN

Chlorotic Anaemia of unknown origin (duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Blood count

(Signed) W. H Pearce, M. D.

, 19 (Address) 2051 E. Clark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 13 1922
20 UNDERTAKER J. F. Sudmeier	ADDRESS one north Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Full information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Infonia Brocato

90 D 60202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60202

1-PLACE OF DEATH Municipal Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infonia Brocato

(a) RESIDENCE. No. 1309 N Bunting ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Wid.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hosp Records
(Address)

15 Filed JAN 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10-1922

17 I HEREBY CERTIFY, That I attended deceased from 1-10-1922 to 1-10-1922 that I last saw h alive on 1-10-1922 and that death occurred, on the date stated above, at 8:50 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde O'Neill, M. D.

1-10 1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cem. Jan 13 1922

20 UNDERTAKER — ADDRESS

John O'Mitchell 1201 N. Fayette

CAUSE OF DEATH in plain terms. Signature of physician is required. Omission to answer any question will delay burial certificate. TION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2537 W North Av. ST.; 15 WARD)

REGISTERED NO. 161 D 60203

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Lee Manning

(a) RESIDENCE. No. 2537 W North Av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany. 9/22

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of wurk: 000
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Hector E Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Louise Comani

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Louise Manning
(Address): 2537 W. North Av

15 Filed JAN 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be understood. See back of certificates. TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany. 9 1922 to Jany. 11 1922.
that I last saw him alive on Jany 11 1922.
and that death occurred, un the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:
Convulsions
Brain hemorrhage, and 10 to 15 min
very efficient & prolonged resuscitation
(duration) yrs. mos. Dail ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Private
(Signed) E. H. Smith, M. D.
1/11, 1922 (Address) 1601 W. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Jan 11, 1922

20 UNDERTAKER: Wm Cook. — ADDRESS: 502 E. North

Spec.—6-9-19—H. P. Co.—1000 Blks.

Wieredecki

D 60204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60204

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3041 Elliott ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wereciuska

(a) RESIDENCE. No. 3041 Elliott ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov-15-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John Wolczewska 3041 Elliott St

15 JAN 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1921, to Jan 10th, 1922, that I last saw him alive on , 1922, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L. Winner, M. D.

1-11, 1922 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 13 1922

20 UNDERTAKER	ADDRESS
Stephen J Kralkowski	1000 S Eutaw

CAUSE OF DEATH in plain terms. Indefinite answers will not be accepted. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ruff

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60205

CERTIFICATE OF DEATH.

47 D 60205

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Parish N. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Ruff

(a) RESIDENCE. NO. 923 Parish n ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer) Dom

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed JAN 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/26, 1921, to 1/11, 1922, that I last saw h— alive on 1/11, 1922, and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows: Ac. Nephritis 6 wks

and

Carcinoma of Breast 9 mos

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkholder, M. D.

, 19 (Address) 739 W-St-N

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 15 19
20 UNDERTAKER	ADDRESS
Jno. H. Chase	[illegible]

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—R. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60206

CERTIFICATE OF DEATH.

161-001 D 60206

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dabney

(a) RESIDENCE. No. 1140 Division ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 31-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Forman

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Katie Dabney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Katie Dabney
(Address) 1104 Division St.

15 Filed JAN 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3rd, 1921, to Jan. 11th, 1922, that I last saw h[illegible] alive on Jan. 11th, 1922, and that death occurred, on the date stated above, at 5-10 a.m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis -
(Primary focus not determined)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital -

Did an operation precede death? No Date of

Was there an autopsy? Yes

What lesl confirmed diagnosis? Tumor Pituitary

(Signed) Horace G. Stewart, M. D.

1/11, 1922 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan. 12, 1922
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	1114 N. Sacramento St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60207 ✓ D 60207

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Green & Lombard St. ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank E. Pratt.

(a) RESIDENCE. No. 838 Hamilton Terrace ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lina Lee Pratt

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired. Pol

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa

PARENTS

10 NAME OF FATHER James Pratt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Jane Hanna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Hosp. records.
(Address)

15 Filed JAN 12 1922 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1922

17 I HEREBY CERTIFY, That I attended deceased* from Dec 9, 1921, to Jan 12, 1922

that I last saw him alive on Jan 12, 1922

and that death occurred, on the date stated above, at 10:25 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cachexia & Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Sputum exam.

(Signed) Geo. E. Wells. , M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan 12 1922

20 UNDERTAKER Chas. E. Franck ADDRESS 801 Madison Ave.

CAUSE OF DEATH to be plainly written. Spelling of name and TION is very important. See instructions on back of certificates.

Patten

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60208

CERTIFICATE OF DEATH.

101 D 60208

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Patten

(a) RESIDENCE. NO. 1527 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Patten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Harriett Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) None

14 Informant (Address) Mrs Carnay 1527 N. Caroline St

15 Filed JAN 12 1922 ROBERT R. KRAFFT Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1922, to Jan. 11, 1922, that I last saw him alive on Jan. 11, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) Frank C. Manno, M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 13 1922
20 UNDERTAKER Henry Lutz	ADDRESS 203 N. Broadway

CAUSE OF DEATH must be stated. Physician's certificate must be filed with Registrar before burial permit is issued. See back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 60209

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 60209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Asquith ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Lee Chandler

(a) RESIDENCE No. 1906 Asquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chield

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE — Years 14 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Robert Lee Chandler Sen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Clarkrill Va

12 MAIDEN NAME OF MOTHER Blanch Marron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Clarkrill Va

14 Informant Father Robert-Lee Chandler
(Address) 1906 Asquith St

15 Filed 1 2 1922, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1922

17 I HEREBY CERTIFY, That I attended deceased from January 10 1922, to January 11 1922, that I last saw him alive on January 11, 1922 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. Kennard M. D.

, 19 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clarkrill Va

DATE OF BURIAL Jan 13 1922

20 UNDERTAKER Mrs Robert-A Elliott

ADDRESS 1225 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60210

D 60210

CERTIFICATE OF DEATH.

178

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1814 Maryland Ave ST.: 17 WARD)

2-FULL NAME Zack Lewis

(a) RESIDENCE. No. 1814 Maryland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) Station Work

(c) Name of employer B. & O. Railroad

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Robt Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jane Lewis
(Address) 519 Mulberry

15 Filed 1922 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10-1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1922 to — 19 .
that I last saw him alive on Jan 10 1922.
and that death occurred, on the date stated above, at 1.10 a m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis (Coma)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jas C Carter, M. D.

19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gulcan Burial	Jan 13 1922
20 UNDERTAKER John Wanderer	ADDRESS 1532 Pennsylvania

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Carper said over phone that he knew nothing of his former condition, and could get no history.

Not reported in Nursing Division.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60211

CERTIFICATE OF DEATH.

90 D 60211

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1600 E: Federal st. (St.) (8) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Boerner Sr.

(a) RESIDENCE. No. 1600 E: Federal St St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lena Leimbach

6 DATE OF BIRTH (month, day, and year) Aug 9th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	5	

8 OCCUPATION OF DECEASED 043

(a) Trade, profession or particular kind of work Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 18 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lena Boerner
(Address) 1600 E: Federal St

15 Filed 1 2, 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1922 to Jan 10 1922
that I last saw h[illegible] alive on Jan 10 1922
and that death occurred, on the date stated above, at 7.45 P m.
The CAUSE OF DEATH* was as follows:
Mitral Regurgitation & Heart.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Loss of Compensation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gus F Taylor, M. D.

1 12 1922 (Address) 125 E B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Jan 13 1922

20 UNDERTAKER: A Herwig & Bro

ADDRESS: [redacted] Eastern

CAUSE OF DEATH must be plainly written, and TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D 60212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60212

CERTIFICATE OF DEATH.

159

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Eutaw St., 76 WARD)

2-FULL NAME Marino Maggitte

(a) RESIDENCE NO. 2108 Eutaw ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12. 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Butte. Mont
(State or country)

PARENTS

10 NAME OF FATHER Andrew Maggitte

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Laura Graziplenis

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Andrew Maggitte
(Address) 210 S Eutaw

15 Filed 12 1922, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 19 22, to Jan 12, 19 22, that I last saw him alive on Jan 11, 19 22, and that death occurred, on the date stated above, at 2.a m.

The CAUSE OF DEATH* was as follows:

Premature birth
Failure of foramen ovale to close
(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Maxwell L Magruder M. D.

1/12/1922 (Address) 3113 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem

DATE OF BURIAL Jan 13 1922

20 UNDERTAKER J Kenny & Co

ADDRESS 2006 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60213 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60213

CERTIFICATE OF DEATH

91-002

1-PLACE OF DEATH South Balto General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No 224 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Getzinger

(a) RESIDENCE. No. 1123 Battery Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Getzinger

6 DATE OF BIRTH (month, day, and year) April 2, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chas. A. Getzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Madaline Hummel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas A Getzinger
(Address) 1123 Battery Ave.

15 Filed . 19 Robert F. McGrath Registrar
Burial Permit Clerk.

JAN 2 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3 , 1922, to Jan 11 , 1922

that I last saw him alive on Jan. 11 , 1922

and that death occurred, on the date stated above, at 10 25 A. m.

The CAUSE OF DEATH* was as follows:

Endarteritis Obliterans

(duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 5, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Earl F. Benson, M. D.

. 19 (Address) South Balto. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Jan 14th 1922

20 UNDERTAKER	ADDRESS
E. Schlosman & Son	Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Two toes removed for gangrene. Condition due to Endarteritis obliterans. No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60214

CERTIFICATE OF DEATH.

31

D 60214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1225 Light (St.:) 24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis C. Grimm

(a) RESIDENCE. No. 1225 Light St. St., 24 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Grimm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant (Address) Emma L. Grimm 1225 Light St

15 Filed Jan 13 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 11, 1922, that I last saw h[illegible] alive on Jan 10, 1922 and that death occurred, on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Chronic
Pulmonary
Phthisis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Jan 11, 1922 (Address) 101 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 13 1922

20 UNDERTAKER: E. Ishleman & Son ADDRESS 1039 Hanover

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

NOV 2 1922

Spec.—1-10-21—M&T—1500 Blks.

D 60215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60215

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2809 Hudson St. (St.) (Ward) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Eugene Fischer

(a) RESIDENCE No. 2809 Hudson St. (St.) / WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothea Fischer

6 DATE OF BIRTH (month, day, and year) May-2-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Propriator 086

(b) General nature of industry, business, or establishment in which employed (or employer) Md, Bleach & Dye Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Germany~~

14 Informant Dorothea Fischer (Wife)

(Address) 2809 Hudson St.

15 Filed JAN 12 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEAT

16 DATE OF DEATH (month, day, and year) Jan. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1921, to Jan 10, 1922, that I last saw him alive on Jan 10, 1922, and that death occurred, on the date stated above, at 7.45P m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Caleb A. Athey, M. D.

July 12 1922 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Jan. 13 1922

20 UNDERTAKER Lilly & Feiler ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION is very important. See instructions on back of certificates.

Spen.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60216

CERTIFICATE OF DEATH.

X 52

D 60216

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE (No. Lombard & Green St. 4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Wilson

(a) RESIDENCE. No. Texas, Md. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Nancy Belle Wilson

6 DATE OF BIRTH (month, day, and year) ? - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	—			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Section Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Outside work

(c) Name of employer Penn. Railroad.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James A. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital records (Address)

15 Filed Jan 12 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12/22 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 . 1922 . to Jan 12 . 1922 . that I last saw him alive on Jan 12 . 1922 . and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus c Pyelitis Cause.

CONTRIBUTORY (Secondary) Carbuncle - Back of Neck (duration) yrs. 5 mos. ds.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Texas, Maryland.

Did an operation precede death? Yes. Date of 1/7/22.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) K. B. Johns, M. D.

1/12, 1922 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
E. Le Roy Stiffler Texas Md	Jan 15, 1922
20 UNDERTAKER Texas Md	ADDRESS
125 E North Ave	

Pine Grove Cem. Texas Md (Walters Sta.)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60217

CERTIFICATE OF DEATH.

11-007

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2603 Greenmount ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Barbour

(a) RESIDENCE. No. 2603 Greenmount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 225

6 DATE OF BIRTH (month, day, and year) June 17-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	22	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Loyd E. Barbour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. York

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant (Address) Warren Culbertson 2937 E. Ave., City

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 1922, to Jan 11 1922,

that I last saw h alive on Jan 11 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza & Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Alan B Newman, M. D

1/12/1922 (Address) 710 N Patterson Pk Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harwood Chapel Cem. Balto Co.

DATE OF BURIAL Jan 14 1922

20 UNDERTAKER E. LeRoy Steffey

ADDRESS 124 E Monument ave

JAN 12 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered on back of certificates. TION is very important. See instructions on back.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60218

101-001

D 60218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1072 Granby ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Cunningham

(a) RESIDENCE NO. #1072 Granby ST., — WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Cunningham

6 DATE OF BIRTH (month, day, and year) Oct 22, 1880

7 AGE Years	Months	Days	If LESS than 1 day, — hrs or — min.
41	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster D W D

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph C. Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Annie Rooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Fannie Cunningham (Address) 1072 Granby Stey

15 Filed ..... 19 Robert P. Hartleroy Registrar

NOV 2 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1922, to Jan 10, 1922, that I last saw h[illegible] alive on Jan 9, 1922, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Lobar (Double) Pneumonia.

(Both lungs involved)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Frank A. Smith, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 13 1922
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60219

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 60219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Guilford Ave & Preston St.

REGISTERED NO.

CITY OF BALTIMORE: (No. Preston Apartments ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Carroll Weatherly

(a) RESIDENCE NO. Preston Aparts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Owen J. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Maria Southerland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Carroll D. Weatherly

(Address) Preston Aparts

15 Filed 1922 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922, to Jan 11, 1922

that I last saw her alive on Jan 11, 1922

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

OVER

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Septic Infection

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? Yes Date of Dec 29

Was there an autopsy? No

What test confirmed diagnosis? Blood Test

(Signed) Jno B Thomas, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh N. C.	Jany 13 1922
20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for bad bowels. Infection probably from throat.

D 60220

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D 60220

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Edmondson Ave cor Pt. near Nunnery Lane ST.: 28 WARD)

2-FULL NAME Melvin S Griffett

(Residence in Baltimore: No. Edmondson Ave near Nunnery Lane St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: January 26, 1862 (Month) (Day) (Year)

7-AGE: 59 yrs. 11 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: President Seeds
(b) General nature of industry, business, or establishment in which employed (or employer): Griffith Frame Co

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: John M. Griffith

11-BIRTHPLACE OF FATHER (State or country): Balt Co.

12-MAIDEN NAME OF MOTHER: Rose Julia Chamedon

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sue Ray Griffith

(Address) Edmondson Ave cor Pt.

15 Robert F. Harrison, Burial Permit Clerk.

Filed JAN 12 1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January 11, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Jan 11 1922, that I saw him alive on Jan 11, 1922, and that death occurred, on the date stated above, at 12 10 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & dilated heart, acute Heart Disease

1 hr

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) (over)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Marshall B Hurst M. D.

Jan 12, 1922 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted. If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL: Jany 13, 1922

20-UNDERTAKER: John O Mitchell ADDRESS: 120 W Fayette St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. Fractions of a year or month may be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

dropsy, heart, with failure of compensation. James McTeuter (Coroner)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train — accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D 60221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60221

CERTIFICATE OF DEATH.

93

REGISTERED NO.

1-PLACE OF DEATH C. S. Duncan at

CITY OF BALTIMORE: (No. 220 Shlman St ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie ~~Gordon~~ Powe

(a) RESIDENCE NO 220 S Shlman ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 11 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	55	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House keeper 86

(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

(c) Name of employer: James Gordon

9 BIRTHPLACE (city or town) (State or country): Co Wexford Ireland

PARENTS

10 NAME OF FATHER: Wm Powe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wexford Ireland

12 MAIDEN NAME OF MOTHER: Dooley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Co Wexford Ireland

14 Informant: Jamye Gordon

(Address) 220 E. Duncan St

15 Filed 19 Robert F. Harrison, Burial Permit Clerk. Registrar

12 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 1921, to Jan 11 1922,

that I last saw h Co alive on Jan 9 1922,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pancreas rules Impacted

by Streptococcus Group I

Septicemia

(duration) yrs. 4 mos. 11 ds.

CONTRIBUTORY (Secondary) Chron Septicemia

(duration) 1 yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) Daniel F Wiehe, M. D.

, 19 (Address) 533 Cathedral Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 14 1922
20 UNDERTAKER	**ADDRESS**
William J Schaeffer	1816 Monument

IMPORTANT: Physician must fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

State 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60222

CERTIFICATE OF DEATH.

D 60222

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 15 WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Olivia Finney

(a) RESIDENCE. No. 2010 McKean Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mr. George Finney

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Duffield Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mercy Hosp. Records.
(Address)

15 Filed JAN 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922, to Jan 11, 1922

That I last saw her alive on Jan 11, 1922

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Carbuncles

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan 8, 1922

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms.

(Signed) Ben Gerson, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 13 1922

20 UNDERTAKER George J. Smith ADDRESS 1000 N. Dugdale St

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 60223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60223

CERTIFICATE OF DEATH.

100-007

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1122 Sarton St.; Morrell Park Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paige Bennett Klein

(a) RESIDENCE. No. 1022 Sarton St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Fred. H. Klein

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Bennett

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Frederick H. Klein.
(Address) 1122 Sarton St.

15 Filed JAN 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 11, 1922.

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1922, to Jany 11, 1922, that I last saw h[illegible] alive on Jany 8, 1922, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo L. McKibbin, M. D.

Jan 11 1922 (Address) Morrell Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet.	Jan 13 1922

20 UNDERTAKER George D. Smith. ADDRESS [illegible] Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60224

D 60224

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 W. Monument ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Green

(Residence in Baltimore: No. 218 W. Monument St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1861 (Year)

7-AGE, 61 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), St. Marys Co. Md

PARENTS.

10-NAME OF FATHER, John Green

11-BIRTHPLACE OF FATHER (State or Country), St. Marys Co. Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Buttony

(Address) 626 Jasper St

15- Filed JAN 13 1922, 191... ROBERT R. KRAUTER, Burial Permit Clerk ..... Registrar.

CAUSE OF DEATH must be plainly written, and every important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 10th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31st 1921, to Jan 10th 1922, that I saw h e alive on Jan 9th 1922 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Ch. Parenchymatous Nephritis - Tendency to Coma

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) None Known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Keller, ... M. D.

Jan 12, 1922 (Address) 2226 W. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, Jan 13 22

20-UNDERTAKER Saml. T. Hemsley

ADDRESS 578 W. Baltimore St.

Spec.—1-10-21—M&T—1500 Bks.

D 60225 HEALTH DEPARTMENT—CITY OF BALTIMORE

88 D 60225

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 N. Monroe St. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie A Ebberts

(a) RESIDENCE NO. 234 N. Monroe St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 26 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER W. H. Ebberts

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Charlotte Mills

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant

(Address)

15 Filed JAN 13 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11th 19 22

17

I HEREBY CERTIFY, That I attended deceased from Jan 8. 1922, to Jan 12 1922,

that I last saw h alive on Jan 11. 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pneumonia Acute

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W W Thayer, M. D.

19 22 (Address) 1735 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Jan 16 1922

20 UNDERTAKER Joseph B. Cook

ADDRESS 1033 Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 D 60226

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. St Joseph Hosp. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Brinck.

(a) RESIDENCE. NO. 1047 Shields Alley. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (City or town) (State or Country) Baltimore City Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (City or town) (State or Country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (City or town) (State or Country) Not known

14 Informant John R. Smith (Address) 1047 Shields Ale

15 Filed JAN 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1921 to Jan 11 1922

that I last saw her alive on Jan 11 1922

and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows: over

Generalized peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infected fibro-myoma uteri.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 8, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. C. Mamo, M. D.

, 19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan 14 1922

20 UNDERTAKER David Gordon ADDRESS 916 Gay ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Source of infection unknown.
Nonmalignant.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 60227

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Thompson

(a) RESIDENCE. NO. 895 Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 107

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Wm. Washington,

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Angeline Kiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JAN 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from December 14, 1921, to January 8, 1922, that I last saw her alive on January 8, 1922, and that death occurred, on the date stated above, at 11:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) F. H. Brumbach, M. D.

1/9/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 13 22
20 UNDERTAKER David Fearon.	ADDRESS 916 Fo ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact should be verified. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60228

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1416 N. Gilmor (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Rose Barbour

(a) RESIDENCE. No. 1416 N. Gilmor St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of William Barbour.

6 DATE OF BIRTH (month, day, and year) 9-6-1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

10 NAME OF FATHER John Benjamin Kerin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Brothier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Barbour
(Address) 1416 N. Gilmor St.

15 Filed JAN 13 1922 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1922

17 I HEREBY CERTIFY, That I attended deceased from January 1st, 1917, to January 11, 1922, that I last saw h.er alive on January 11, 1922, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Fatty overgrowth of heart.

(duration) at least 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Obesity

(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Chester Ruland, M. D.

1-11, 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 14 22
20 UNDERTAKER	ADDRESS 916
David Carter	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence must be given. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 60229

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60229

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore, Md

REGISTERED NO.

CITY OF BALTIMORE: (No. 705 Carrollton Ave. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Burgess Bruce

(a) RESIDENCE NO. 705 Carrollton Ave WEST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia A. Bruce.

6 DATE OF BIRTH (month, day, and year) June 19, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist 055

(b) General nature of industry, business, or establishment in which employed (or employer) Not important

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William H. Bruce

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Annie Burgess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Anna Louise Bruce (Address) 705 N. Carrollton Ave.

15 JAN 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to Jan 12, 1922, that I last saw him alive on Jan 12, 1922 and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary haemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Pulmonary Tuberculosis (duration) 4 yrs. 7 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) A D Tagumby, M. D.

, 19 (Address) 721 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
David Ridge	Jan 14 1922

20 UNDERTAKER John A. Mitchell ADDRESS 1801 W. Fayette

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 60230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60230

CERTIFICATE OF DEATH.

121

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Dept of Prisons St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.)
Male	White	Unknown

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 087

9-BIRTHPLACE, (State or Country), Unknown

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roberta Talbot Slater

(Address) Bank & Wash Broadway

15- Filed JAN 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigations (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Cutting Throat

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Sumwalt Coroner's M. D.

(Address) 100 Holliday

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Hebrew Mt Carmel	1/13, 1922
20-UNDERTAKER	ADDRESS
Jack Levin	1411 Balto St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. may be properly classified.

Spec.—1-10-21 M&T 1500 Bks.

D 60231

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 1 D 60231

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2802 Ulman ave ST., 15 WARD)

2-FULL NAME Dorothy Lauenthal

(a) RESIDENCE NO. 2802 Ulman ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 24 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nathan Lauenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Hannah Mann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Jack Lewis 1411 E Balto St

15 Filed JAN 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5th, 1922, to Jan. 12th, 1922.

That I last saw h[illegible] alive on Jan. 12th, 1922.

and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

4 mos ds.

(duration)

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Chas. C. Habliston M. D.

1/13 1922 (Address) 1315 Mt. Royal Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 1/13 1922

20 UNDERTAKER Jack Lewis 1411 E Balto St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60232

CERTIFICATE OF DEATH.

K 100 D 60232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4203 Pinehurst Ave ST.; 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Angele Bullough.

(a) RESIDENCE. No. 4203 Pinehurst Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is necessary TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 3, 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER George T. N. Bullough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn, N.Y.

12 MAIDEN NAME OF MOTHER Ruth Angele

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington County, Md.

14 Informant Mother
(Address) 4203 Pinehurst Ave

15 Filed . 19 JAN 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1922

17 I HEREBY CERTIFY, That I attended deceased from January 9, 1922, to January 12, 1922, that I last saw him alive on January 12, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? auscultation

(Signed) Harry E. Wilson, M. D.

, 19 (Address) 1836 Park Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D C.	Jan 14 1922

20 UNDERTAKER Harry W. Ethlen ADDRESS 1944 W. North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinol fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60233

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 60233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. #2753-Maryland-Ave. ST.: 12 (WARD) 19

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ROSE CHESHIRE GREER

(a) RESIDENCE No..... #2753-Maryland-Av. ST. 12 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 59 yrs. 11 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John James Greer.

6 DATE OF BIRTH (month, day, and year): Jany-31-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Henry Ingle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alexandria Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Lloyd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Culpepper Virginia

14 Informant: Mrs. Viola I. Vrooman, (niece), (Address) 624-Randolph-St. N. W. Washgtn, D. C.

15 FILED JAN 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to June 12, 1922, that I last saw h er alive on June 12, 1922, and that death occurred, on the date stated above, at about 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Mitral Insufficiency

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? a

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis of side

(Signed) Jno A Lutscher, M. D.

June 13 1922 (Address) 1025 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
D. C. LOUDON PARK CEMETERY.	Jan-14-22

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 103 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CASE IS TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60234 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 60234

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #2632-Maryland-Ave. ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Clay Smith

(a) RESIDENCE. No. #2632-Maryland-Av. ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? 65 yrs. 2 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Augusta Smith

6 DATE OF BIRTH (month, day, and year): Nov-9-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: R. R. Ticket Salesman. 67 3

(b) General nature of industry, business, or establishment in which employed (or employer): Calvert Station.

(c) Name of employer: Penna. R. R. Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Charles A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Waynesboro, Penna.

12 MAIDEN NAME OF MOTHER: Catherine Sheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Waynesboro, Penna.

14 Informant: Mrs. Emma A. Smith, (wife)
(Address) 2632-Maryland-Ave, City.

15 JAN 13 1922 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 11. 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 17. 1922, to Jan 11. 1923, that I last saw h[illegible] alive on Jan. 9. 1922, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon.

About (duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia Saccharina

About (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 25. 1921

Was there an autopsy? No

What test confirmed diagnosis? Macroscopical

(Signed) H. A. Stanbury, M. D.

Jan 11 1922 (Address) 714 Park Ave, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY	Jan-13-22

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 103 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60235

CERTIFICATE OF DEATH.

31 D 60235

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Otto

(a) RESIDENCE. No. 1600 E. Fayette st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 37 — Unknown mos. 27 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) FEB-15-1884 1884 - FEB-15/84

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
37	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Oscar Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Rausch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records
(Address) M.T.H.

15 FILED JAN 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30 1921, to Jan. 11 1922, that I last saw him alive on Jan. 11 1922, and that death occurred, on the date stated above, at 12.05 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis J. Dalaglisen, M. D.

1-11-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: JAN-13 1922

20 UNDERTAKER: F.B. Wippert

ADDRESS: 2236 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. FULL ANSWERS TO ALL QUESTIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60236

CERTIFICATE OF DEATH.

57 D 60236

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1943 West Pratt ST. 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Albrecht

(a) RESIDENCE NO. 1943 W Pratt Street ST. Same WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie E. Albrecht

6 DATE OF BIRTH (month, day, and year) April 21 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fred'k Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Blankenbuehler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katie E. Albrecht (Address) 1943 W. Pratt St

15 JAN 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1922

17 I HEREBY CERTIFY, That I attended deceased from November, 1920, to January 11, 1922, that I last saw him alive on January 11, 1922 and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes
Arteriosclerosis
(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cancer diabeticum
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. A. Morgan, M. D.

1/12, 1922 (Address) 2438 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL JAN-14 1922

20 UNDERTAKER F B Wagner — ADDRESS 2236 Fred'k Av

mation should be carefully supplied. ... that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be ... check of certificates.
TION is very important. See instructions on back of ...

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60237

CERTIFICATE OF DEATH.

57

D 60237

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 E. North Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Fred C. Reisinger

(Residence in Baltimore: No. 1727 E. North Ave St.; 25 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, August 8, 1847
(Month) (Day) (Year)

7-AGE, 72 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Fred Reisinger

(Address) 1727 E. North Ave

15-

Filed JAN 13 1922 191.... ROBERT R. KRAUTER. Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1921, to Jan. 9, 1922, that I saw him alive on Jan. 7 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart

(Duration) 2 yrs. 6 mos. ds.

(Signed) J. Albert Lingenfelter, M. D.

1/10, 1922. (Address) 1413 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	JAN 13, 1922
20-UNDERTAKER	ADDRESS
A. S. Thuppert	2236 Frederick Ave

Spec.—5-19-13—M. & T.—500 Bks.

Bolisewicki V

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 60238

D 60238

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 S. Elwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Joseph Bolisewski

(Residence in Baltimore: No. 926 S Elwood Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan. 8th (Month) (Day), 1922 (Year)

7-AGE, ...yrs. ....mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jano Bolisewski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Jana Zielinska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bolisewski

(Address) 926 S Elwood Ave

15- Filed JAN 13 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 12th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9th 1922, to Jan 12th 1922, that I saw him alive on Jan. 9th 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Premature birth 8 mos pregnancy

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jno R Byrne M. D.

Jan 12th, 1922 (Address) 1223 S Ethan St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem

DATE OF BURIAL, Jan 13, 1922

20-UNDERTAKER Stephen J Frackowski

ADDRESS 1125 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60239

REGISTERED NO. 129 D 60239

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 815 E. Chase (St.) 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Coyne

(a) RESIDENCE No. 815 E. Chase St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Patrick Coyne

6 DATE OF BIRTH (month, day, and year): Dec 2 - 1847

7 AGE — Years: 74 | Months: 1 | Days: 9 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Duken

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Beatrice Shannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Anthony Coyne 815 E. Chase St.

15 Filed JAN 13 1922 . 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16 1921 to Jan 11 1922

That I last saw h.. alive on Jan 11 1922

and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis + dilated heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 815 E Chase St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Kenton, M. D.

19 (Address) 750 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Jan 14 1922

20 UNDERTAKER: J. C. Windefeld — ADDRESS: 917 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60240

CERTIFICATE OF DEATH.

74-061 D 60240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. Belnord Avenue St.: 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANNA RUSSY

(a) RESIDENCE. No. 722 N. BELNORD AVENUE St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Jan. 23~~ Jan 13 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Anton Kubisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Roma Paul
(Address) 722 N. Belnord Avenue

15 JAN 13 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1921, to Jan. 11, 1922,

that I last saw her alive on Jan. 11, 1922,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

6 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Krauter, M. D.

1/12/22 19 (Address) 801 N. KENWOOD AVENUE

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bohemian Cem.

DATE OF BURIAL: Jan 15 1922

20 UNDERTAKER: Jos. J. Merz

ADDRESS: 152 N. Luzerne ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60241

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 60241

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Alicanna ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Steve Weyer

(Residence in Baltimore: No. 1510 Alicanna St.: 1 yrs. 3 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, October (Month) 8 (Day), 1920 (Year)

7-AGE, 1 yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer) — None

9-BIRTHPLACE, (State or Country), Baltimore. Md.

PARENTS.

10-NAME OF FATHER, Peter Weyer.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore. Md

12-MAIDEN NAME OF MOTHER Lottie Krebs

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Weyer

(Address) 1510 Alicanna St.

15- Filed ....., 191.... Robert F. Harrison, Registrar.

Burial Permit Clerk.

N 13 1922

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 13 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1922, to Jan 13 1922, that I saw him alive on Jan 13 1922, and that death occurred, on the date stated above, at 5:05 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) Frank J[illegible] M. D.

Jan. 13., 1922 (Address) 243 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus Cem. DATE OF BURIAL. Jany. 16., 1922

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Ann St

D 60242 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60242

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH City of BALTIMORE: (No. Mercy Hospital St. 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell T. Higginbothom (Residence in Baltimore: No. Bel Air Md. 2 Years. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 13 (Day) 1916 (Year)

7-AGE, 5 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work School Boy (b) General nature of Industry, business, or establishment In which employed (or employer)

9-BIRTHPLACE, (State or Country). Elkton City Md.

PARENTS

10-NAME OF FATHER, Delaney C. Higginbothom

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Conway

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Delaney C. Higginbothom

(Address) Main St. Bel Air, Md.

15- Robert P. Harrison, Filed 192 Burial Permit Clerk. Registrar.

N 13922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 13 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH was as follows: Automobile Accident Multiple Fractures.

(Duration) yrs. mos. 2 hrs. ds.

CONTRIBUTORY (Secondary) Shock (Duration) yrs. mos. 2 ds.

(Signed) J. C. Blades M. D. (Coroner)

Jan 13 1922 (Address) 143 N. Amay

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bel Air Md.

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Howard Co. DATE OF BURIAL, Jan 16 1922

20-UNDERTAKER, Easton Sons ADDRESS' Elkton Md

State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. It is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60243

REGISTERED NO. 164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2651 W North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sophronia K. Childs

(a) RESIDENCE. (No.) 2651 W North Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wh	Widow

5a If married, widowed, or divorced (or) WIFE of Jno D. Childs

6 DATE OF BIRTH (month, day, and year) Dec. 27th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 400

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Aquilla Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs Geo. W. Miller 2651 W. North Ave

15 Received ..., 19... Registrar

JAN 13 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 1921, to January 12 1922, that I last saw her alive on January 12 1922, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Gradual weakening due to old age - no disease discovered.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Refusal of medicine or nourishment (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. Smith M. D.

1/13 1922 (Address) 1628 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Park — DATE OF BURIAL: Jan 14th 1922

20 UNDERTAKER: Bertram Fore — ADDRESS: 1753 W Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60244

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Noe

(a) RESIDENCE NO. 516 N. Patterson Park Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Charles Noe

6 DATE OF BIRTH (month, day, and year) Oct 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) America

PARENTS

10 NAME OF FATHER Andrew Jorgenbuck

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) America

12 MAIDEN NAME OF MOTHER ~~Elizabeth~~ Kratz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) America

14 Informant Hospital Records
(Address)

15 Filed Robert P. Harrison,
Registrar
JAN 13 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1922, to Jan 11 1922

that I last saw her alive on Jan 11 1922

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Anemia

Chr Nephritis?

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Vincents Angina

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Smears of throat Blood chemistry

(Signed) A Hirsberg, M. D.

1/11, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Jan 15 1922

20 UNDERTAKER Wm C. Miller — ADDRESS 2534 Jefferson St

Information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60245

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1453 Covington ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

• 2-FULL NAME Charles P. Bethmann

(a) RESIDENCE. NO. 1453 Covington St WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6.24.1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Carver

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Eliz Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Chas P Bethmann
(Address) 1453 Covington St

15 Filed JAN 13 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1.10 1922

17 I HEREBY CERTIFY, That I attended deceased from 12 9 1921, to 1.10 1922, that I last saw h living alive on 1.10.1922, and that death occurred, on the date stated above, at 11.45 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Vascular Hemorrhage

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 wks 4 days ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. J. Darlington, M. D.

111. 1922 (Address) 102 E York ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Oliver Cem	1/14/ 1922
20 UNDERTAKER	ADDRESS
John J Gahagan Sons	1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITIONS IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47

D 60246

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 S. Fremont Ave ST.) 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea S. Braecklein

(a) RESIDENCE. No. 609 S. Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Braecklein

6 DATE OF BIRTH (month, day, and year): Jan 10th 1846

7 AGE: Years 76 Months — Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of Industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Albert Seidler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louise Gibson (Address) 609 S. Fremont Ave.

15 Filed Jan 13 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

N 13 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 12th 1921, to Jan 12th 1922, that I last saw h.er alive on Jan 12th 1922, and that death occurred, on the date stated above, at 9.45 A.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary): Carcinoma of Breast

(duration) 4 yrs. — mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Poulton, M. D.

1922 (Address) 654 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 14th 1922
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John K. Teufel & Son	801 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. PARA... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60247

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 5605 York Road. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Richardson.

(a) RESIDENCE. No. 5605 York Road. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles A. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Julia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Louise Phillips
(Address) 5605 York Road

15 Filed ....., 19.. Robert P. Harrison, Registrar

1 31922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13/22 1922.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1922, to Jan. 13, 1922; that I last saw her alive on Jan. 13, 1922, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Ureteo-Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron Interstitial Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Harris. M. D.

1-13. 1922 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 16/21 1921
20 UNDERTAKER	ADDRESS
Wm. Cook.	501 E Nalt

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LANGUAGE OF PHYSICIAN is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60248 ✓ 90 D 60248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1907 Kennedy Ave. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie J. Simmons

(a) RESIDENCE No. 1907 Kennedy Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Daniel H. Simmons

6 DATE OF BIRTH (month, day, and year) 10. 23. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56		2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) Owings Mills
(State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Henry Glenn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Katherine Ellis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Co. Md.

14 Informant Daniel H. Simmons
(Address) 1907 Kennedy ave

15 Filed Robert P. Harrison, Registrar
JAN 13 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 13 1922.

17 I HEREBY CERTIFY, That I attended deceased from September 1 1920 to January 13 1922, that I last saw h[er] alive on January 12 1922, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart
Mitral Reg. Insuf.
(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) General Dropsy
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Curtis H. A. Meyer M. D.

13. 1922 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Jan 16/22
20 UNDERTAKER	ADDRESS
Wm. Cook	508 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 60249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60249

CERTIFICATE OF DEATH.

1922 45

197 REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital ST. 8 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wade H. Wheeley

(Residence in Baltimore: No. 1518 N Port St. St.: yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 5, 1877
(Month) (Day) (Year)

7-AGE, 45 yrs. 11 mos. 8 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Storekeeper, 045
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Thomas Wheeley.

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER ? Don't Know

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Maude Wheeley
(Address) 1518 N. Port St.

15- Robert F. Harrison, ..., 191.....
Burial Permit Clerk. Registrar.

D 13 1922

Every item of information should be carefully supplied. ASK if doubtful. CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Homicide. Shot by
Pistol
(Duration) .....yrs.....mos.....ds.
CONTRIBUTORY (Secondary)
(Duration) .....yrs.....mos.....ds.
(Signed) H. J. Mealey, M. D.
(Coroner.)
....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel. Cem
DATE OF BURIAL, 1—14..., 1922

20-UNDERTAKER Wm Cook.
ADDRESS 502 E Moth Ave.

D 60250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 60250

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2404 W Lombard ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles D. Barnett

(Residence in Baltimore: No. 2404 W Lombard St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Feb (Month) 26 (Day), 1873 (Year)

7-AGE, 48 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Glass Furnace

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER, Dudley Barnett

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Louise White

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Therese Barnett

(Address) 2404 W Lombard St.

15- Filed ....., 191.... Registrar.

Robert P. Harrison,

JAN 3 1922 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Compression by Hanging

Suicide

Duration ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Melancholy State

Duration 3 yrs. ..... mos. ..... da.

(Signed) James H Fenton M. D. (Coroner.)

Jan 13, 1922 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Jan 16 1922

20-UNDERTAKER Wm. Cook ADDRESS 502 E. North

Spec. 6-19—H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60251

D 60251

1530 91

1-PLACE OF DEATH

CITY OF BALTIMORE: No. ST.: 7 WARD:

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter L. Skinner

(a) RESIDENCE. No. Glenville Gilmore Co ST.. WARD Glenville W. Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown West Va mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Florence Skinner

6 DATE OF BIRTH (month, day, and year) Dec. 6th 1892

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Worker

(b) General nature of industry, business, or establishment in which employed (or employer) — 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER John William Skinner

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Anna Holt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant (Address)

15 Filed JAN 13 1922 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1922 to Jan 13, 1922.

that I last saw h[illegible]live on Jan 13th 1922

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

Cerebral embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Glenville W. Va.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksburg West Va	Jan 14 1922

20 UNDERTAKER Joseph Abrams ADDRESS 221 Bway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60252 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60252

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 632 Pine St. ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah L. Gilmore (Or, if child, Name of Child)

(Residence in Baltimore: No. 632 Pine St. 71 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1851 (Year)

7-AGE. 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE. (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Taylor

(Address) 632 Pine St.

15- Robert P. Harrison,

Filed ..... 191 ..... Registrar.

JAN 14 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or inquiry.~~ thereon and from the evidence obtained by said ~~Inquest, au-~~ ~~topsy or inquiry.~~ found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary disease of the heart

(Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H. H. Young (Coroner.) M. D.

1/13, 1922 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cemetery

DATE OF BURIAL, Jan. 15. 1922

20-UNDERTAKER J. Lowe Hall

ADDRESS 1741 Druid Hill ave

N.B.—Every item of information should be carefully supplied. ACCURACY in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60253 — 58-01 — D 60253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 12 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Cavanaugh

(a) RESIDENCE No. 412 E. 25th St. City ST.
(Usual place of abode)

WARD

(If non-resident give City or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. 63 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Margaretta Cavanaugh

6 DATE OF BIRTH (month, day, and year) Nov. 1858

7 AGE: Years 63 yrs. Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Dennis Cavanagh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Cavanagh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James Cavanaugh

(Address) 412 E. 25th St.

15 Filed ....., 19.... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4 1921 to Jan. 13 1922.

That I last saw him alive on Jan. 13 1922

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure — Pulmonary Oedema 24 hrs.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Lab Exam Blood

(Signed) C. C. Eldridge, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan 16 1922

20 UNDERTAKER: Henry Koeck & Son — ADDRESS: 1301 E. Eager

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. The information called for in every item is required by law. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60254

CERTIFICATE OF DEATH

D 60254

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. 6 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Browne

(a) RESIDENCE No. Havre, France ST., WARD Havre, France
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Browne

6 DATE OF BIRTH (month, day, and year) Nov. 13 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 037

(b) General nature of industry, business, or establishment in which employed (or employer) Lady.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Otho E Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Henrietta S. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ellen H. Ridgely (Address) 1007 N. Calvert St.

15 Filed 1 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13 19 22

17 I HEREBY CERTIFY, That I attended deceased from 12/28, 19 21, to 1/13, 19 22, that I last saw her alive on 1/13, 19 22, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
(Post Operative)
Pelvic Peritonitis - 0030

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Operation 12/31/21
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12/31/21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H B Kneely M. D.

1/13, 19 22 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem — DATE OF BURIAL 1-16 1922

20 UNDERTAKER Howard Jenkins Geo & Sons Co — ADDRESS McCulloh Orchard.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 60255 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 15 D 60255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 777 W. Cross ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Rumney

(a) RESIDENCE No. 777 W. Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Rumney

6 DATE OF BIRTH (month, day, and year) Sept 8-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	3	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work City Employment

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City

(c) Name of employer Court House

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert Rumney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Henritta Dea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Millard F. Rumney (Address) 807 Mansfield St.

15 Filed JAN 11 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1921, to Jan 11, 1922, that I last saw him alive on Jan 10, 1922, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Contusion of (Neck)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 12/28/21

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edw Grumbine M. D.

1/18. 1922 (Address) 817 London St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Jan 14 1922

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pratt St.

AW 1 1922

PRINTED BY THE WM. T. SMITH CO.

...mation should be carefully supplied. AGE should be stated PARTICULARLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60256 — CERTIFICATE OF DEATH. — D 60256

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Franklin Sq. Hospital; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremy Brown

(Residence in Baltimore: No. Laurel Md. St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept 10, 1912 (Month) (Day) (Year)

7-AGE, 9 yrs. 4 mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country) Anne Arundel Co, Md

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER Rachel Bowie

13-BIRTHPLACE OF MOTHER (State or Country) Prince George Co, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Brown

(Address) Laurel Md

15- Robert F. Harrison

Filed ..., 191... Registrar.

JAN 14 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1922, to Jan 13 1922, that I saw him alive on Jan 13 1922, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis,

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

... (Duration) ... yrs. ... mos. ... ds.

(Signed) H. C. Wenrick M. D.

Jan 13, 1922 (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 1 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Laurel, Md.

Former or usual residence Laurel Md.

19-PLACE OF BURIAL OR REMOVAL, Crater Laurel Md. DATE OF BURIAL, Jan 15, 1922

20-UNDERTAKER Samuel M. Clarke Inc. ADDRESS 1400 M st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

REGISTERED NO. 74-005 60257

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Hicks

(a) RESIDENCE. No. Unkno ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Hicks

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anna Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JAN 14 1922 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to January 10, 1922, that I last saw him alive on January 10, 1922, and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

1/12/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan 15th 1922
20 UNDERTAKER	ADDRESS
Sam. W. Chase-son	1400, Monument

mation should be carefully supplied. All spaces must be filled. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60258

CERTIFICATE OF DEATH

REGISTERED NO. 179

1-PLACE OF DEATH Sorrel Baltimore

CITY OF BALTIMORE: (No.) 1213 Light St (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Timson

(a) RESIDENCE. No. 1010 W Franklin St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Richard H. Timson

6 DATE OF BIRTH (month, day, and year): Aug 6, 1853

7 AGE: Years 68; Months 6; Days 7; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Robert Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah Tolle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Raleigh D. Timson
(Address) 1010 W. Franklin St

15 Filed JAN 14 1922

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1922 to Jan 13, 1922, that I last saw him alive on Jan 13, 1922, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Partial (4yr)

What test confirmed diagnosis?

(Signed) Jesse Price Wilkerson M. D.

, 19 (Address) Balt City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Jan 16 1922

20 UNDERTAKER: Alfred S. Little — ADDRESS: 2750 Edmondson

JAN 14 1922

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60259

D 60259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 420 N. Gilmor ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Noah Butler

(Residence in Baltimore: No. 420 N. Gilmor St ST.; 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	Col.	Married

6-DATE OF BIRTH, Nov. 20, 1873
(Month) (Day) (Year)

7-AGE, 48 yrs. 1 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: U.S. Collector
(b) General nature of industry, business, or establishment in which employed (or employer): Preacher

9-BIRTHPLACE, (State or Country), Louisiana

PARENTS.

10-NAME OF FATHER, Aron Butler

11-BIRTHPLACE OF FATHER (State or Country), Louisiana

12-MAIDEN NAME OF MOTHER Clark Lucas

13-BIRTHPLACE OF MOTHER (State or Country), Louisiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Butler

(Address) 420 N. Gilmor

15-

Filed Jan 14 1922, 191

Robert P. Harrison
Burial Permit Clerk. Registrar.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION likely to be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 1922, to Jan. 12 1922, that I saw him alive on Jan. 12 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Intest Obstruction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Oedema of the lung.

(Duration) yrs. mos. 12 ds.

(Signed) J. N. Thayer M. D.

Jan 12, 1922 (Address) 1313 N. Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Jan 15, 1922
20-UNDERTAKER Brown & Ecclard	ADDRESS 114 W. Saratoga St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60260

D 60260

CERTIFICATE OF DEATH.

150804

44

1-PLACE OF DEATH

CITY OF BALTIMORE: No. ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kelly or Boyd Langdon

(a) RESIDENCE. No. 125 N. 11th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-2-1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53.	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Danville Pa

PARENTS

10 NAME OF FATHER Steve Kelly or Geo. Langdon

11 BIRTHPLACE OF FATHER (city or town) Sussex Co. (State or country) N. J.

12 MAIDEN NAME OF MOTHER Theresa Knorr

13 BIRTHPLACE OF MOTHER (city or town) Warren Co (State or country) N. J.

14 Informant (Address)

15 Filed 1922 Robert F. Harrison, Registrar

JAN 14 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12 1922.

17 I HEREBY CERTIFY, That I attended deceased from 1-6 1922, to 1-12 1922,

that I last saw him alive on 1-12 1922,

and that death occurred, on the date stated above, at 5-25-4 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Jan 11th 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 14 1922

20 UNDERTAKER John H. Denny ADDRESS 715 Light St

S 6030

mation should be carefully supplied. Age should be given in years, months and days. Exact statement of OCCUPA-
may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60261

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 W. Biddle ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie Kyler

(Residence in Baltimore: No. 515 W. Biddle St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 55 yrs. 9 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, dont no

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER dont no

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Kyler

(Address) 515 W. Biddle St

15-

Filed ..... 191.....

ROBERT P. HARRIGAN, Registrar.

JAN 21 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 11th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31- 1921, to Jan 11 1922
that I saw h-m alive on Jan 8 1922,
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

1 Gangrene of R. foot
(Diabetes)
(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes mellitus not known
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Keller M. D.

Jan 13th, 1922 (Address) 324 W. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
mt auburn cemetery	Jan 15 1922
20-UNDERTAKER	ADDRESS
John H. Todd	142 N. Hill St

N.B.—Every question must be answered, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60262

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2nd ave 19 St.: 76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leona Marie Haas

(a) RESIDENCE. No. 2nd ave 19 St., 26 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Katherine E Altvater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) George Haas 14 W 2nd ave

15 Filed JAN 14 1922 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 14 1922

17 I HEREBY CERTIFY, That I attended deceased from 1 7 . 1922 . to 1 14 . 1922

that I last saw her alive on 1 13 . 1922

and that death occurred, on the date stated above, at 3.15 a m.

The CAUSE OF DEATH* was as follows:

DTH

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace Fitlow, M. D.

, 19 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel cem.	1/14 1922
20 UNDERTAKER	ADDRESS
Zurkler & Zurkler	1739 E. Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60263

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Yingling

(a) RESIDENCE. No. 4001 Eastend Ave St.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Clarence Yingling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Cora C Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs T. Brown
(Address) 512 S 13th St

JAN 14 1922 Filed ..... 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1922, to Jan. 12, 1922
that I last saw him alive on Jan 12, 1922
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? S. T. S. - Laboratory

(Signed) Frank C. Marino, M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 16 1922
20 UNDERTAKER J Herwig & Co	ADDRESS 2108 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

(Von Lossberg)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60264 — 74 — D 60264

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 628 W Barre. ST.: 77 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Von Lossberg

(a) RESIDENCE. No. 628 W Barre St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or WIFE of): Louise Von Lossberg

6 DATE OF BIRTH (month, day, and year): Oct 26 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer): Piano work

(c) Name of employer: Kuabes

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ernst Von Lossberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louise Von Lossberg (Address) 628 W Barre

15 Filed Jan 14 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

N 14 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 1922 to Jan. 13 1922

that I last saw him alive on Jan 12-22

and that death occurred, on the date stated above, at 2 30 m. Am

The CAUSE OF DEATH* was as follows:

Apoplexy - 6 (duration) yr. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis 2 6 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L L Swisinger M. D.

1/13 1922 (Address) 628 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 14 22
20 UNDERTAKER	ADDRESS
Harry A. Witzke	1531 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH—

CITY OF BALTIMORE (No. 3921 Ridgewood Ave 15 WARD)

REGISTERED No. C 74-001

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. M. Hall.

Residence in Baltimore: No. 3921 Ridgewood Ave, St.: 3 yrs., 6 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, Mar. 24, 1842
(Month) (Day) (Year)

7-AGE, 79 yrs. 1 mos. 18 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Shoemaker

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Louis Hall

11-BIRTHPLACE OF FATHER (State or Country), Connecticut

12-MAIDEN NAME OF MOTHER Mary Morton

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie E. Ethal

(Address) 3921 Ridgewood Ave

15-

Robert F. Harrison

Filed ..... 191..... Clerk.

Registrar.

JAN 16 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 13, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ....yrs. ....mos. 1 ....da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....da.

(Signed) J. T. Hennessy M. D.
(Coroner)

Jan 13, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn DATE OF BURIAL. Jan. 16 1922

20-UNDERTAKER Wm. Hickman ADDRESS 1004 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 60266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60266

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 Walbrook ST., 15 WARD)

2-FULL NAME Henry F. Mylander

(a) RESIDENCE NO. 2028 Walbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie Mylander

6 DATE OF BIRTH (month, day, and year): Aug. 22 1857

7 AGE: Years 64 Months 11 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westphalia Europe

PARENTS

10 NAME OF FATHER: Fredk Mylander

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Lillie Mylander

(Address): 2028 Walbrook Ave

15 Filed JAN 14 1922

Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. It may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that TION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1921, to January 12 1922, that I last saw him alive on January 12, 1922 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Squamous cell, of mediastinum and neck

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of July 14, 1921.

Was there an autopsy? No

What test confirmed diagnosis? Pathological section.

(Signed) C. S. Koffman, M. D.

, 19 (Address) 2100 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 14 1922

20 UNDERTAKER: Wm J. McKinstrie — ADDRESS: North Ave

D 60267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60267

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. North ave 733 St. 29 Ward)

2-FULL NAME Mrs Francis L. Harbaugh

(Residence in Baltimore: No. North ave & 33rd St.)

REGISTERED NO. C 488

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If under 1 yr., 59 yrs., 3 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 19, 1892 (Month) (Day) (Year)

7-AGE, 29 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Clarence S. Bonis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Hattie Moore

13-BIRTHPLACE OF MOTHER (State or Country), Wash. D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence S. Bonis

(Address) North Ave. & 33rd St. ~~Washington~~

15- Robert P. Harrison

Filed ..... 191.... Burial Permit Clerk.

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 12, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or inquiry) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull. Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

191.... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, London Park

DATE OF BURIAL, Jan. 16 1922

20-UNDERTAKER Wm J. Tickner & Son

ADDRESS N. Ave & Pa

Filed JAN 14 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60268

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No) 130 Dolphin ST.: 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minder Brown

(a) RESIDENCE. No. 130 Dolphin ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~ Married, ~~Widowed, or Divorced~~ (write the word)
Male	Black	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50,			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 150

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant
(Address)

15 Filed ..... 19 ..... Registrar

JAN 14 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 26th, 1921, to Jan 11th, 1922.

that I last saw him alive on Jan 11th, 1922

and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Oedema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Lew. H. Lafferybach M. D.

Jan 14 1922 (Address) 2215 N. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Robert P. Harrison
Burial Permit Clerk

N.B.—WRITE PLAINLY. All items must be stated EXACTLY. PHYSICIAN should be careful in stating CAUSE OF DEATH. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60269

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp. St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Jennings

(a) RESIDENCE. No. N & C Hosp St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Patsie Nettley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila., Pa.

12 MAIDEN NAME OF MOTHER Marie Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

11

Informant

(Address)

Filed JAN 14 1922, 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12th 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1921, to Jan 12th, 1922,

that I last saw her alive on Jan 12th, 1922,

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nutritional Decomposition.

(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mal J Faughn, M. D.

, 19 (Address) 2007 E. Balt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60270 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60270

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Upton ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Roscoe Jerome Watkins

(a) RESIDENCE. NO. 1209 Upton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 8 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Linnell Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City Md.

12 MAIDEN NAME OF MOTHER Lillian Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D. C.

14 Informant Mrs. Linnell Watkins
(Address) 1209 Upton St.

15 Filed JAN 14 1922 Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8 , 1922, to Jan. 12 , 1922, that I last saw him alive on Jan. 12 , 1922, and that death occurred, on the date stated above, at 7-40 P. m.

The CAUSE OF DEATH* was as follows:

Lack of development.
Premature birth. 7 months baby

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCarthy, M. D.

. 19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetary	Jan 15 1922

20 UNDERTAKER ADDRESS

Chas. C. Bailey 142 Lafayette

Spec.—6-9-19—H. P. Co.—1000 Pks.

10309r Medical 60271

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 60271

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Neal

(a) RESIDENCE. NO. 1225 Cattum St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Curtis Neal

6 DATE OF BIRTH (month, day, and year) ? 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Judy Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address)

15 Filed JAN 14 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12th, 1922, to Jan. 12th, 1922, that I last saw h[illegible] alive on Jan. 12th, 1922, and that death occurred, on the date stated above, at 4:40 p.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency - 14 Mos.

Syphilis (duration) 17 yrs. mos. ds.

Toxic insufficiency (unknown)

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Chemistry. Microscopic exam.

(Signed) Francis L. Eisenäide, M. D.

Jan 13. 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbury Cemetery	Jan 15 1922
20 UNDERTAKER	ADDRESS
Chas L Bailey	1421 Johnson

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 2906 Mosher St. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm B. Stafford

(Residence in Baltimore: No. 2906 Mosher St St.; yrs., mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Widower

6-DATE OF BIRTH, Jan 26, 1 (Month) (Day) (Year)

7-AGE, 73 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer): Undertaker

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Charles T. Milton

(Address) 2906 Mosher St

15-

Robert P. Harrison,

Filed....., 191.... Registrar.

JAN 14 1922 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 1922, to Jan 12 1922, that I saw h[illegible] alive on Jan 12 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Chronic hypertrophy of the heart associated with mitral lesion

at 3 yrs. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic tonsilitis Nephritis

(Duration) 10 yrs. mos. ds.

(Signed) Joseph M. Zierer M. D.

Jan 13, 1922 (Address) 1003 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Charles Co Md

19-PLACE OF BURIAL OR REMOVAL, Charles Co Md Cedarmount M E Church

DATE OF BURIAL, Jan 15, 1922

20-UNDERTAKER W M Routson

ADDRESS 2238 N Mott

(409 Courtland St)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60273 ✓ D 60273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 409 St. Paul Place, St. 4 WARD) Registered No. C 167

2-FULL NAME Abraham Sykes.

(Residence in Baltimore: No. 401 Burton St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 78 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1844 (Year)

7-AGE, 78 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER .....

11-BIRTHPLACE OF FATHER (State or Country), ...

12-MAIDEN NAME OF MOTHER .....

13-BIRTHPLACE OF MOTHER (State or Country), ...

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore St

15-

Robert F. Harrison,

Filed ..... 191.....

Registrar.

JAN 14 1922 Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 11 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Jan death on the day stated above.

The CAUSE OF DEATH was as follows:

Asphyxia
Self Gas
Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Granville Wade M. D.
(Coroner)

Jan 11, 1922 (Address) 1 E Mt Vernon Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship

DATE OF BURIAL, 1 — 15, 1922

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Baltimore St

All widows print Suicide

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60274

CERTIFICATE OF DEATH.

74-001 D 60274

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 121 E. 27th St. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Roach

(a) RESIDENCE NO. 121 E. 27 ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? 75 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Roach

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

800

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs Byrnes

(Address) 121 E 27th St.

15 Filed Jan 14 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1921, to Jan 14, 1922

that I last saw h er alive on Jan 14, 1922

and that death occurred, on the date stated above, at 12 m. a. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Gabrielson M. D.

Jan 14 1922 (Address) 112 W. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan. 17 1922

20 UNDERTAKER: Henry Hoen Sons — ADDRESS: 1301 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. It may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60275

D 60275

CERTIFICATE OF DEATH.

REGISTERED NO. 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 N Monitor St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis J. Learned

(a) RESIDENCE. NO. 1733 N Monitor St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) Dec 8-1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Electric Light. Power &

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston

PARENTS

10 NAME OF FATHER Eric C. Learned

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston, Mass

12 MAIDEN NAME OF MOTHER Elizabeth McAdams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Providence, R I

14 Informant Mrs Learned (Address) 1733 N. Monitor Ave

15 Filed JAN 14 1922 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1922, to Jan 17, 1922

that I last saw h alive on Jan 13, 1922

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Scarlet Fever

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. L. Hedrick M. D

Jan 14 1922 (Address) 301 N Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem	1/15/22

20 UNDERTAKER Chas. F. Evans & Son ADDRESS 1130 W Royal Ave

N. B.—WRITE PLAINLY WITH INK AND DO NOT USE ABBREVIATIONS. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 12 N. Broadway ST.: 6 WARD)

2-FULL NAME Mary E. Golding Korst.

(a) RESIDENCE No. 12 N Broadway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Golding Korst Jr.

6 DATE OF BIRTH (month, day, and year): Oct. 6 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	4	5	

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: John W Noellert.

11 BIRTHPLACE OF FATHER (city or town): Germany
(State or country)

12 MAIDEN NAME OF MOTHER: Not known.

13 BIRTHPLACE OF MOTHER (city or town): Germany
(State or country)

14 Informant: John H Golding Korst Jr.
(Address)

15 Filed JAN 14 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1922, to Jan. 14, 1922, that I last saw h... alive on ... and that death occurred, on the date stated above, at 11 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema - Acute.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): (1) Acute Gastritis (2) Aortic Insufficiency (3) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home 12 N. Broadway

Did an operation precede death? No Date of ...

Was there an autopsy? ... No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Linder, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk. Cem.	1/16 1922
20 UNDERTAKER: L. Hamm.	ADDRESS: 328 Park

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

6P277 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 74-001 160277

6P277 B 60277

CERTIFICATE OF DEATH. REGISTERED NO. B 60277

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 N. Bond ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Mitchell.

(a) RESIDENCE NO. 1630 N Bond. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary S. Mitchell

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	59.	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 015

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER James A Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary S. Mitchell (Address) 1626 N Bond St

15 Filed JAN 15 1922, 19 GG Registrar

JAN 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Jan 13, 1922.

that I last saw h.m. alive on Jan 13, 1922.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R G Davis, M. D.

19 (Address) 1509 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL Jan 16 1922

20 UNDERTAKER Wm Cook ADDRESS 502 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Davis 1509 N Caroline St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

60278

HEALTH DEPARTMENT—CITY OF BALTIMORE

60278

148 D 60278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amy Hildebrand

(a) RESIDENCE. NO. 1817 N Collington Ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred. W. Hildebrand

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alexander Shaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Rehring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Fred. W. Hildebrand
(Address) 1817 N Collington Ave

15 Filed JAN 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/13/ 1922 to 1/13/ 1922

that I last saw her alive on 1/13/ 1922

and that death occurred, on the date stated above, at 11:20 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1/13/21

Was there an autopsy? yes

What test confirmed diagnosis? P.M. + Symptoms

(Signed) Frank C Harper M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 17. 1922
20 UNDERTAKER Mr & Mrs John H Teufel & Son	ADDRESS 501 W. Fayette St

N. B.—NAME FULLY, and PLACE OF DEATH carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Puerperal.

D 60279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 60279

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4211 Liberty Heights Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Soule Rawlings Jr

(a) RESIDENCE. No. 4211 Liberty Heights Ave St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~ Married, ~~Widowed~~ or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of: Mary Rawlings

6 DATE OF BIRTH (month, day, and year): October 12 1869

7 AGE: Years 52 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joshua S Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country): A A Co Md

12 MAIDEN NAME OF MOTHER: M Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary Rawlings

(Address) 4211 Liberty Heights Ave

15 Filed JAN 15 1922 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 12 1921. to Jany 13. 1922

that I last saw h~~im~~ alive on Jany 12. 1922.

and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
Right Lung.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Staphylococcus ~~and~~ pneumococcus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Dr Fuchs in consultation

What test confirmed diagnosis? Pneumococcus found by media supt.

(Signed) A E Pole M. D.

. 19 (Address) 2032 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Jan 16 1922

20 UNDERTAKER: Henry A Jenkins & Son Co — ADDRESS: Orchard & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60280

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60280

8 161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 N. Port ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 8 month monstrosity.

(a) RESIDENCE. NO. 1615 N. Port ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-10-22

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George Lassise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Port Rico

12 MAIDEN NAME OF MOTHER Gertrude Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Gertrude Lassise

(Address) 1615 N Port St

15

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1922

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,

that I last saw h... alive on ..., 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

8 month Monstrosity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Hornstein, M. D.

1/13, 1922 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Carnegie Embalming Lab Johns Hop Rand Lot	ADDRESS

20 UNDERTAKER

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state nation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 6028 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 60281

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 S. Poppleton ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E. Deegan

(a) RESIDENCE. NO. 26 S. Poppleton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 7-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. P.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accl Va.

12 MAIDEN NAME OF MOTHER Cath. B. Pendergast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant C. B. Deegan. (Address) 26 S Poppleton St

15 Filed JAN 15 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1921, to Jan 13, 1922.

that I last saw her alive on Jan 12, 1922.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis.

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) Edw J. Coolahan, M. D.

1/14, 1922 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	1-17 1922
20 UNDERTAKER	ADDRESS
H. C. Manning Son	517 N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT AND PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lungs involved.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60282

D 60282

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp. ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester Roberts

(a) RESIDENCE. No. N & C. Hosp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	13	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Jessie Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kansas City Kas.

12 MAIDEN NAME OF MOTHER Eleanor Hinkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Eleanor Hinkel
(Address) Childs Hospital

15 Filed JAN 15 1922 19 GLS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13th, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 31st 1921 to Jan 13th 1922, that I last saw him alive on Jan 13th 1922, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Intoxication

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Loral D. Spencer, M. D.

19 (Address) 710 W. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 16 1922
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60283

CERTIFICATE OF DEATH.

1799 D 60283

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2434 Fair Ave ST.; 1 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Schmidt.

(a) RESIDENCE. No. 2434 Fair Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. H. Schmidt.

6 DATE OF BIRTH (month, day, and year) Mar. 4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Kahler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER C. Ocks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. Henry Schmidt (Address) 2437 Fair Ave

15 Filed JAN 15 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13" 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1922, to Jan 13th, 1922, that I last saw her alive on Jan 13th, 1922, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Nephritis + Valvular Heart Disease

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) W. H. Schwatka, M. D.

1/13 1922 (Address) 734 S Dellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn, Essex	Jan 16" 1922
20 UNDERTAKER	ADDRESS
Geo M. Fair & Son	511 N. Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60284

CERTIFICATE OF DEATH.

90 D 60284

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 9 W. Lee ST.: 77 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Beinschla

(a) RESIDENCE. No. 9 W. Lee ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Beinschla

6 DATE OF BIRTH (month, day, and year) Dec. 13th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John C. Kipke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Beinschla

(Address) 324 Hanover St.

15 Filed JAN 15 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from October 11th, 1921, to January 13th 1922.

that I last saw her alive on January 12th, 1922.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic Regurgitation of Heart

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) General Anasarca

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleibel M. D.

1/14. 1922 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan 15 1922
20 UNDERTAKER	ADDRESS 1034
J. Lehmann & Son	Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60285

CERTIFICATE OF DEATH.

14-001

D 60285

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. [illegible] St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Joachim Doerfler

(Residence in Baltimore: No. [illegible] St.; 64 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, December 11, 1849
(Month) (Day) (Year)

7-AGE, 65 yrs. 1 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael Doerfler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva Sauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sister Mary Bernetta

(Address)..... Sisters Bon Secours

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14, 1914.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1913, to June 14 1914,
that I saw h.. alive on June 14 1914,
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:

Edema Pulmonis
(Contributory Nephritis)
Diphtheria & Tonsilitis
(Duration) 6 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

(Signed) F. J. Kelly M. D.
June 14, 1914 (Address) 110 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md.	June 16, 1914
20-UNDERTAKER	ADDRESS
Frank A. Tenck	915 E. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60286

CERTIFICATE OF DEATH.

X 101 D 60283

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1024 Division St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Claude F. Brown

(a) RESIDENCE. No. 118 Cherry St St., Ward.
(Usual place of abode) Asheville, N.C.
Length of residence in city or town where death occurred yrs mos 17 ds. How long in U. S., if of foreign birth? yrs mos ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola F. Brown

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 666

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Frank Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Silvia Hampden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Frank Brown (Address) Asheville N.C.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1922, to Jan 14, 1922, that I last saw him alive on Jan 14, 1922, and that death occurred, on the date stated above, at 8:10 h. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Rt.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George E. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Asheville N.C. Jany 15 1922

20 UNDERTAKER — ADDRESS

John O. Mitchell 120 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60287

CERTIFICATE OF DEATH.

113 D 60287

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 Pine St.; 4 WARD) 4

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Brashear

(Residence in Baltimore: No. 315 Pine North St.; .....yrs. .....mos. .....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. Ethiopian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH. March 7, 1921
(Month) (Day) (Year)

7-AGE. .....yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....mIn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) City

PARENTS.

10-NAME OF FATHER. Webster Brashear

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Louvinia Brashear

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen E. Brashear

(Address) 315 Pine St.

15-

Filed....., 191.....

.....Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922, to Jan 13 1922, that I saw h.. alive on Jan 13 1922, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows: Ulcerative Gastro Colitis.

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) .....yrs. .....mos. 19 ds.

(Signed) C. F. Matthews, M. D.

Jan 14, 1922 (Address) 1240 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn

DATE OF BURIAL. Jan 17, 1922

20-UNDERTAKER Clarence E. Wright

ADDRESS 1504 W. Cary

Spec.—1-10-21—M&T (1500 Blks)

D 60288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14,001

D 60288

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2010 Brunt ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Johnson

(a) RESIDENCE NO. 2010 Brunt ST., WARD 8 Fmd

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? ✓ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of dead

6 DATE OF BIRTH (month, day, and year) Dec 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	4	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lobbying

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ellen Smith

(Address) 2010 Brunt St

15 Filed , 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/12, 1922 to 1/13, 1922

What I last saw him alive on 1/12, 1922,

and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

Hemoplegia

Ovst

(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Fen Lee M. D.

, 19 (Address) 922 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bk Cemetery	Jan 16th 1922
20 UNDERTAKER	ADDRESS
Clarence E Wright	1324 W Cary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic Hemiplegia
No terminal Hemorrhage

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60289

CERTIFICATE OF DEATH.

139

D 60289

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1449 (Street) Henry St.; 24 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon L. Wright

(a) RESIDENCE. No. 1449 E Henry St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bucks Co Pa.

PARENTS

10 NAME OF FATHER Harry N. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bucks Co Pa.

12 MAIDEN NAME OF MOTHER Catherine Cadwallader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bucks Co Pa.

14 Informant Phillip Calladan

(Address) 1449 E Henry St

15 Filed JAN 15 1922

16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Jan 13, 1922, that I last saw h~~im~~ alive on Jan 13, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell, M. D.

B. 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Jan 19 1922

20 UNDERTAKER	ADDRESS
William Cook	526 E Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60230

CERTIFICATE OF DEATH.

H1 D 60290

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 15 WARD)

2-FULL NAME John Crouse

(a) RESIDENCE NO. 1534 Fremdsbury Pl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life Time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Crouse

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	35 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cement- work

(b) General nature of industry, business, or establishment in which employed (or employer): 083

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or couptry): " " "

14 Informant: Mrs. Annie Crouse

(Address): 1534 Fremdsbury Ave

15 Filed JAN 15 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1922.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1921, to Jan. 14, 1922.

that I last saw him alive on Jan. 14, 1922;

and that death occurred, on the date stated above, at 1½ P. m.

The CAUSE OF DEATH* was as follows:

Pyemia - multiple Abscesses -

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Cardiac Failure Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Dec 12-21

Was there an autopsy? No

What test confirmed diagnosis? Operation - Blood Culture

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem — DATE OF BURIAL: Jan 17 1922

20 UNDERTAKER: Wm Cook. — ADDRESS: 502 E North ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—8-24-14—M. & T.—2000 Blks.

D 60291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60291

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Maryland Ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Dawson Barnes.

(Residence in Baltimore: No. 2716 Maryland Ave. St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, March 4th, 1839
(Month) (Day) (Year)

7-AGE, 82 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired Mfr
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Builder

9-BIRTHPLACE, (State or Country), Princess Anne Co. Va.

PARENTS.

10-NAME OF FATHER, Joshua N. Barnes

11-BIRTHPLACE OF FATHER (State or Country), Princess Anne Co. Va.

12-MAIDEN NAME OF MOTHER Sarah E. Dawson

13-BIRTHPLACE OF MOTHER (State or Country), Norfolk, Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Washington Barnes

(Address) Norfolk, Va.

15-

Filed JAN 15 1922 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 13th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10th 191 , to Jan 13th 1922 , that I saw h living alive on Jan. 13th 191 2, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis Chronic
Mitral Regurgitation

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Fred'k R Ross M. D.

Jan 13 1922, (Address) 2709 Ind. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery DATE OF BURIAL, Jan. 17 ..., 1922

20-UNDERTAKER William Cook ADDRESS 502 E Norfolk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60292 — 1-001 — D 60292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 717 S. Fremont Ave ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy B Frazier

(Residence in Baltimore: No. 717 So Fremont Ave St.: 3 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	

6-DATE OF BIRTH, Unknown (Month) (Day), 1906 (Year)

7-AGE, 16 yrs. mos. ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): Girl

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Allen Frazier

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Mary Lemar

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Frazier

(Address) 717 S Fremont Ave

15- DG

Filed JAN 15 1922, 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 13 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1921, to Jan 13 1922, that I saw her alive on 1/12 1922, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D H Case M. D.

Jan. 14, 1922 (Address) 500 N. Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. moe. ds. — In the State yrs. moe. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Jan 17, 1922
20-UNDERTAKER Brown & Kilgus	ADDRESS 1140 W Lexington St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 60293

CERTIFICATE OF DEATH.

74 D 60293

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1225 Hanover ST.: 23rd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas A. Frank

(a) RESIDENCE. No. 1225 Hanover ST., 23rd WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced.~~ HUSBAND of ~~(or) WIFE of~~ Augusta Frank.

6 DATE OF BIRTH (month, day, and year) Oct 5th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mich.

PARENTS

10 NAME OF FATHER Charles Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Isabella Albert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Augusta Frank (wife)
(Address) 1225 Hanover St

15 Filed JAN 15 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from February 4th 1921, to January 12th 1922.

that I last saw him alive on January 12th 1922.

and that death occurred, on the date stated above, at 9 25 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) — yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Weibel M. D.

1/14. 1922 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer. Cem.	1—16 1922
20 UNDERTAKER	ADDRESS
E & B Harle	115 E West St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60294

CERTIFICATE OF DEATH 1113

D 60294

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 80 3rd Ave (St.) Hagners Point (Ward) 35

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Joseph Haase

(a) RESIDENCE No. 80 - 3rd Ave. (St.) Hagners Point City (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) East Brooklyn

PARENTS

10 NAME OF FATHER Rudolph Haase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dora Brauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rudolph Haase
(Address) Hagners Pt. Balto Md.

15 Filed JAN 15 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1922 to ....., 19.....

that I last saw h alive on ....., 19.....

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

Malnutrition

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm P Horca, M. D.

Jan 13, 1922 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (A&C) — DATE OF BURIAL 1-15 1922

20 UNDERTAKER E. B. Harle — ADDRESS 115 E. Lexington St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-12—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60295 — 0 01 — D 60295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 N Eutaw Place St.) (WARD) 14

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Wagner

(Residence in Baltimore: No. Glenbernie Md St.; 48 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH: May 29th, 1873 (Month) (Day) (Year)

7-AGE: 48 yrs. 7 mos. 15 ds.

If LESS than 1 day. ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Joseph Wagner

11-BIRTHPLACE OF FATHER (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Barbara Schmuck

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Joseph Wagner

(Address): Glenbernie Md.

15-

Filed JAN 17 1922, 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: January 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1922 to Jan 13 1922, that I saw h[illegible] alive on Jan 13 1922, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) E B Truman M. D.

1/13, 1922 (Address) 412 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross (Md Co) DATE OF BURIAL: 1-17-, 1922

20-UNDERTAKER: E & B Hartz ADDRESS: 115 E West St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60296

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 60296

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: [redacted] 1506 Riverside Ave St. [redacted] 24 W.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted] Patrick Burns

(a) RESIDENCE. No. [redacted] 06 Riverside Ave St.

(Usual place of abode) WARD [redacted]

(If nonresident give city or town and State)

Length of residence in city or town where death occurred about 85 yrs. How long in U. S., if of foreign birth? 85 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary M. Burns

6 DATE OF BIRTH (month, day, and year): Mar. 17, 1828

7 AGE — Years: 93 — Months: 9 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: G & O Ry. 573

(b) General nature of industry, business, or establishment in which employed (or employer): Labor.

(c) Name of employer: ~~Unknown~~

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Wm. Burns

(Address) 1506 Riverside Ave

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Jan 14, 1922, that I last saw h[illegible] alive on June 14, 1922, and that death occurred, on the date stated above, at 3 am m.

The CAUSE OF DEATH* was as follows:

Senile myocarditis

Mitral lesion

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Dilatation of heart & Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ~~yes~~

(Signed) Jas Norman Wm. O'Connell Death Report.

, 19 (Address) 107 E Mt Royal Ave Balto M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Jan 16 19 22

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60297

CERTIFICATE OF DEATH.

74 D 60297

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 45 E. Woodland Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Frances Henderson

(a) RESIDENCE. No. 45 E Woodland Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Levin S. Henderson

6 DATE OF BIRTH (month, day, and year) Feb 9 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) House-work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Worcester Co Md.

PARENTS

10 NAME OF FATHER John Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md

12 MAIDEN NAME OF MOTHER Catherine Merrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Worcester Co Md

14 Informant Florence Stewart
(Address) 45 E. Woodland Ave

15 Filed . 19 Registrar

JAN 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1922 to Jan 13 1922

that I last saw her alive on Jan 13 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bullock, M. D.

Jan 13 1922 (Address) 4852 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 16 1922

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60298

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60298

CERTIFICATE OF DEATH.

162

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby, Gallion

(a) RESIDENCE. NO. Darlington, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13, 1922

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER William Elwin Gallion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County, Md

12 MAIDEN NAME OF MOTHER Sarah Riles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County, Md.

14 Informant Mrs. Sarah Riles
(Address) Darlington Md.

15 Filed JAN 15 1922 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 13, 1922 to Jan 15 1922

that I last saw h alive on Jan 15 1922

and that death occurred, on the date stated above, at 12 30 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Stanley A. Mankus M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Darlington Md. — DATE OF BURIAL: 1-16 1922

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60299

CERTIFICATE OF DEATH.

44 D 60299

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. 33 North Luzerne Ave. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Adam Starr.

(a) RESIDENCE. No. 33 North Luzerne Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Margaret Starr

6 DATE OF BIRTH (month, day, and year) Feb 3. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Merchant 017

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER James H. Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sarah J. Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Gatrude L. LaMar
(Address) 331 N. Luzerne ave.

15 Filed . 19 Registrar

JAN 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 14, 1922, that I last saw h. alive on Jan 14, 1922, and that death occurred, on the date stated above, at 10 35 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver & stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

1/14, 1922 (Address) 2040 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan. 17/22 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60300

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

74 D 60300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3824 Bonnar Road ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ohrmann

(a) RESIDENCE. No. 3824 Bonnar Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover, Germany

PARENTS

10 NAME OF FATHER Henry Ohrmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Oldenroth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernestine Ohrman
(Address) 3824 Bonnar Road

15 Filed JAN 15 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13. 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1922, to Jan 13, 1922, that I last saw h[illegible] alive on Jan 13, 1922, and that death occurred, on the date stated above, at 11.50 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
Haemaplegia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis (Renal)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas L Schaumpell, M. D.

1/24. 1922 (Address) 2806 Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 16/22 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

MAKE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 D 60301

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3517 Cedar Ave ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank-D. Moran Jr

(Residence in Baltimore: No. 3517 - Cedar Ave. St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	single

6-DATE OF BIRTH. Oct 16, 1921 (Month) (Day) (Year)

7-AGE. ..... yrs. 2 mos. 3 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Francis D Moran Sr.

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Catherine E McClain

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis D. Moran Sr.

(Address) 3517 Cedar Ave

15- LG

Filed JAN 9 1922, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 15, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and upon inquiry thereon and from the evidence obtained by said Inquest, and upon inquiry, find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation
Accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	Jan 16, 1922

20-UNDERTAKER Franklin W Sertz ADDRESS 3615 Anthony Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60302

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3517 Cedar ave ST.: 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Moran

(Residence in Baltimore: No. 3517 - Cedar ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. 16, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 30 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....nil
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Francis L Moran Sr

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Catherine E McElroy

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis L Moran Sr.

(Address) 3517 Cedar Ave

15-

Filed ....., 191.... Registrar.

JAN 16 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 15, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation

Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Jan 17 1922 (Address) 3632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan 16, 1922

20-UNDERTAKER Franklin W Seitz

ADDRESS 3613 Hickory Ave

R. C. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 60303

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60303

164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Bank ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Henkel

(a) RESIDENCE NO. 1734 Bank ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) ...
(State or country) Germany

PARENTS

10 NAME OF FATHER John Henkel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Eggert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant J. F. Miller
(Address) 1734 Bank St

15 Filed JAN 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1921, to Jan 12, 1922,
that I last saw h[illegible] alive on Jan 12, 1922,
and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Senility -

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure -

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. E. Bonnell, M. D.

14/1/-19 (Address) 1705 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Jan 16 1922
20 UNDERTAKER	ADDRESS
L. Sander Sons	1210 Pine St.

N. B.—THESE BLANKS ARE FOR RECORDS ONLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60304 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 60304

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lizzie Henson

(a) RESIDENCE. NO. 1742 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co., Maryland

PARENTS

10 NAME OF FATHER Steven Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co. Maryland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JAN 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from January 11, 1922 to January 11, 1922 that I last saw her alive on January 11, 1922 and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Dyde McKee M. D.

1/12/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 DISPOSAL OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Peters Cem — Jan 16 22

20 UNDERTAKER — ADDRESS

Groff Holland — 1631 Hrmd St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-1925-5
1-5-19 Surgical

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 60305

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. ..... ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julian Taylor

(a) RESIDENCE. No. 1606 Etting St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Taylor

6 DATE OF BIRTH (month, day, and year) July 1 - 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Blanche Taylor
(Address) 1606 Etting St

15 Filed JAN 16 1922, 19 ROBERT P. KRAUSS Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11th, 1922, to Jan. 13th, 1922, that I last saw h[illegible] alive on Jan. 12th, 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemmorrhage,

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/2/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cet	1/16/22 19

20 UNDERTAKER P. C. Gross ADDRESS 406 Mordecai

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60306 6 HEALTH DEPARTMENT—CITY OF BALTIMORE 1003

CERTIFICATE OF DEATH.

188 D 60306

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Hoch

(Residence in Baltimore: No. 3818 Edmondson Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, ... Jan (Month) 7 (Day) 1871 (Year)

7-AGE. 50 yrs. 11 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE. (State or Country): Balto

PARENTS.

10-NAME OF FATHER, Peter Phillips

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Rauscher

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Hoch

(Address) 3818 Edmondson

15- Filed JAN 16 1922, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture base of Skull
Internal Injuries
Auto accident

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) James McFenton M. D. (Coroner)

Jan 14, 1922 (Address) 1700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Balto + Carlton Ave

Former or usual residence 3818 Edmondson Ave

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem — DATE OF BURIAL, Jan 17, 1922

20-UNDERTAKER Jos Joerndens Son — ADDRESS 217 S. Bro...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60307

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Wilkowitz

(a) RESIDENCE No. 1936 Orleans ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Wilkowitz

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Wilkowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Wilkowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 E Balto St

15 Filed JAN 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1922, to Jan. 14, 1922, that I last saw her alive on Jan. 14, 1922, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Chronic Myocarditis
Acute Cardiac Failure
?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus
(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Urinary findings.

(Signed) Moses Feldman, M. D.

1/14, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 1/16 1922

20 UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60308

157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1408 Marshall (St.) 23 (Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris May Geisz

(a) RESIDENCE. No. 1408 Marshall St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 20 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER William Geisz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Esther Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mr Wm. Geisz
(Address) 1408 Marshall

15 Filed JAN 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Jan 14, 1922, that I last saw h[illegible] alive on Jan 14, 1922, and that death occurred, on the date stated above, at 9 8 m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes no Date of Jan 13 14

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm L Stiefler, M. D.

1/16, 1922 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	1/16 1922
20 UNDERTAKER	ADDRESS
J Fenwick Colby	130 E Fort

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 60309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 60309

1-PLACE OF DEATH
CITY OF BALTIMORE: No. St. Joseph Hospital ? WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sara Mst Richardson

(a) RESIDENCE No. 625 Hellville Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert O. Richardson

6 DATE OF BIRTH (month, day, and year) Aug. 22-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 03
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mississippi

PARENTS
10 NAME OF FATHER U. D. Hisx
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mississippi
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mississippi

14 Informant Robt. O. Richardson
(Address) 625 Hellville Ave

15 JAN 16 1922 Filed 19 ROBERT R. KRAUER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to Jan. 15, 1922, that I last saw h[illegible] alive on Jan. 15, 1922 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Puerperal septicaemia

(duration) yrs. mos 7 ds.
CONTRIBUTORY (Secondary) Childbirth -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood
(Signed) E. J. Bouchelle, M. D.
19 (Address) 2104 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cemetery Mrs	Jan. 18 1922
20 UNDERTAKER	ADDRESS
Wm Cook Sons	E North

Penn. RR To Robert O. Richardson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60310

CERTIFICATE OF DEATH.

179 ✓ D 60310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 N Broadway ST., 8 WARD)

2-FULL NAME Rosella Steer

(a) RESIDENCE NO. 1525 N. Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles E Steer

6 DATE OF BIRTH (month, day, and year) Sept 20th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ~~OD~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Florence Steer
(Address) 1525 N. Broadway

15 Filed , 19 Burial Permit Clerk
JAN 16 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 , 1922, to Jan 14 , 1922, that I last saw h e alive on Jan 13 , 1922 and that death occurred, on the date stated above, at 6.15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Hardy G Beach , M. D.

, 19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan 17th 1922

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3907 Springdale Ave. (WARD) 12

2-FULL NAME Rosamond Reiner

(a) RESIDENCE. NO. 3907 Springdale WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1-001

101 D 60311

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Emanuel Reiner

6 DATE OF BIRTH (month, day, and year) 3/17/57

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home 037
(b) General nature of industry, business, or establishment in which employed (or employer) housework
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emanuel Schleisner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mirian Krumskopf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Emanuel Reiner
(Address) 3907 Springdale Ave.

15 Filed JAN 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 14th 1922

17 I HEREBY CERTIFY, That I attended deceased from January 10. 1922. to Jany 14th. 1922. that I last saw h[illegible] alive on Jany 14th. 1922. and that death occurred, on the date stated above, at 3 45P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis Symptoms. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.
Jan 15, 1922 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	1/16/22

20 UNDERTAKER	ADDRESS
David Sondheim	1182 W. Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60312

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

D 60312

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 909 Linden Ave ST.) 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Reed.

(Residence in Baltimore. No. 909 Linden Ave - St.; 37 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Don't Know, 1885
(Month) (Day) (Year)

7-AGE, 37 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work. Tailor
(b) General nature of industry, business, or establishment in which employed (or employer). 80

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Andrew Reed

11-BIRTHPLACE OF FATHER (State or Country), Md,

12-MAIDEN NAME OF MOTHER Hannah Credit

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Reed

(Address) 435 Orchard St.

15-

Filed JAN 16 192 ROBERT R. KRAUTER, 191
Burial Permit Clerk
Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 13, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) (No history of the nature of the above)

(Duration) yrs. mos. da.

(Signed) J. A. J. Hennessy M. D.
(Coroner)

Jan. 13. 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Jan. 16 1922

20-UNDERTAKER Daniel Hendley & Bro ADDRESS 1718 E. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60313

CERTIFICATE OF DEATH.

33

D 60313

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1352 Calhoun ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Washington

(a) RESIDENCE. No. 1352 Calhoun ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916 Jan 29

7 AGE Years 5 Months 11 Days 16 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Moody

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frederick Washington
(Address) 1352 N. Calhoun st

15 Filed JAN 16 1922, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14 — 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-28-, 1921, to 1-14-, 1922, that I last saw h-e alive on 1-13- 1922, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) ....yrs. 10 mos. ....ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W R Boykin, M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 16th 1922
20 UNDERTAKER	ADDRESS
Sam. W. Chase — m	1400 Hoshen st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tuberculous condition of intestine.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60314

CERTIFICATE OF DEATH.

460 D 60314

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Dukeland Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mathilda Ludwig

(Residence in Baltimore: No. 611 Dukeland Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 9, 1869 (Month) (Day) (Year)

7-AGE, 52 yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Baltimore city, Md.

PARENTS.

10-NAME OF FATHER, Louis Brunier

11-BIRTHPLACE OF FATHER (State or Country), Bitsch, Germany

12-MAIDEN NAME OF MOTHER Johanna Disler

13-BIRTHPLACE OF MOTHER (State or Country), Dulatza, Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas F Wasmus

(Address) 2039 W. Pratt st

15-

Filed JAN 16 1922, 191.. Registrar. J E Welsh

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1921 to Jan. 13, 1922, that I saw her alive on Jan 12, 1922, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Labia Majora

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. Dickey M. D.

Jan 14, 1922 (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Jan. 16, 1922

20-UNDERTAKER Chas F Wasmus

ADDRESS 2039 W. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60315

D 60315

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.: Municipal Tuberculosis Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kaminski

(a) RESIDENCE. No. 935 Harris Alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Kaminski

6 DATE OF BIRTH (month, day, and year) 1957

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kaminski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Teddyoski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address) M.T.H.

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1921, to Jan. 15, 1922, that I last saw him alive on Jan. 14, 1922, and that death occurred, on the date stated above, at 5.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Samuel Bolagliano M. D.

1-15-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	Jany 18. 1922
20 UNDERTAKER	ADDRESS
M. F. Sadowski,	705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60316

CERTIFICATE OF DEATH.

REGISTERED NO. 14-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2522 Pennsylvania ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Anne Stansfield

(a) RESIDENCE. No. 2522 Pennsylvania ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas B Stansfield

6 DATE OF BIRTH (month, day, and year) mch 28-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	9th	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Mansfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Anne Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Wm F Chew
(Address) 2522 Pennsylvania ave

15 Filed JAN 16 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 - 1922 to Jan 13 1922

that I last saw her alive on Jan 11 - 1922

and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2522 Pennsylvania ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Sinuses Edema

(Signed) E E Nichols, M. D.

1-13-1922 (Address) Pikesville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 16 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

60317

HEALTH DEPARTMENT—CITY OF BALTIMORE

60317

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Aisquith ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Bundy

(a) RESIDENCE. NO. 1909 Aisquith ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col.	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Cindy Bundy

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Pittsburg Pa

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa

PARENTS

10 NAME OF FATHER I dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Petersburg Va

12 MAIDEN NAME OF MOTHER I dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raleford N. Carolina

14 Informant Charles Pierce
(Address) 1909 Aisquith St

15 Filed JAN 16 1922, 19.. ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 13 Jan 1922

17 I HEREBY CERTIFY, That I attended deceased from 26/11/1921 to 14 Jan 1922 that I last saw him alive on 13 Jan 1922 and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency, hypertrophy, etc

Immediate (duration) 5 Day yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure about 9 yrs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I dont Know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wheatfield Boyce. M. D.

1/14/1922 (Address) 617 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel. Cem.	Jan 16 1922
20 UNDERTAKER	ADDRESS
Jas M. Skinner	16 E. E. Fred. St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Not luetic. Acute
myocarditis.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60318 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 715 Pennington Ave ST.: 25th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel M. Smith

(a) RESIDENCE. NO. Curtis Bay, Balto. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 12/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2 hr	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Balto, Md

PARENTS

10 NAME OF FATHER Geo. H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn, Md

12 MAIDEN NAME OF MOTHER Maud E. Holbrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Geo. H. Smith 715 Pennington Ave.

15 Filed JAN 16 1922 19 ROBERT R. KRAMER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 14th, 1921, to Jan 14th, 1922 that I last saw her alive on Jan 14, 1922 and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions 12 hrs

OVER

(duration) yrs.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. B. Horton, M.D.

19 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedarhill Cemetery

DATE OF BURIAL Jan 16 1922

20 UNDERTAKER Margaret G. Flynn

ADDRESS Balto Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure." "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Normal birth.
Cause of convulsions unknown.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60319

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH Curtis Bay, Md

CITY OF BALTIMORE (No. Pennington ave Extended ST.) 25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peyton B. Carney

(a) RESIDENCE. NO. Curtis Bay Md ST., 25 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Betty Carney

6 DATE OF BIRTH (month, day, and year): [illegible] 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Store

(c) Name of employer: Jos. L. Gibson

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Harry Carney

(Address) 15 N. Eutaw St.

15 Filed JAN 16 1922 Registrar

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1922 to Jan 14 1922

that I last saw h[illegible] alive on Jan 13 1922

and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows: Heart Failure

(Duration) yrs. at and mos. ds.

CONTRIBUTORY (Secondary): old age & general debility

(duration) yrs. mos. ds. —

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. B. Horton, M. D.

, 19 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Jan 16 1922

20 UNDERTAKER: M. J. Flynn

ADDRESS: Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic organic heart trouble.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60320

88

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1936 E Eager St (St.:) 7 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob J. Wichmann.

(a) RESIDENCE. No. 1936 E. Eager St St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman —

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Hickmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Katherine Samm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lillian Hickmann

(Address) 1936 E Eager St

15 Filed . 19 J. G. Registrar

1161922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st 1921, to Jan 14 1922, that I last saw h alive on Jan 14 1922 and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Epilepsy — 0020

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. Frauenthal M. D

. 19 (Address) 2500 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 17th 1922
20 UNDERTAKER	ADDRESS
Peter Nicolaus	1046 East

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not luetic Acute
myocarditis No further
History

D 60321

HEALTH DEPARTMENT—CITY OF BALTIMORE

1906
188 D 60321

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 21 Agnes Hospital St. 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Burton Butler

(Residence in Baltimore: No. 515 Scott St. 16 yrs., 7 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June 11, 1905
(Month) (Day) (Year)

7-AGE, 16 yrs. 7 mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stock Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Chesapeake Iron Co

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Harry Butler

11-BIRTHPLACE OF FATHER (State or Country) Cumberland Md

12-MAIDEN NAME OF MOTHER Florence Smith

13-BIRTHPLACE OF MOTHER (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Butler

(Address) 515 Scott St

15-

Filed ..., 191...

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

1 16 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Septicaemia following Contusion received at work

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Crushing

(Duration) ... yrs. ... mos. ... ds.

(Signed) James M Farnham M. D.
(Coroner.)

Jan 16, 1922 (Address) 700 E Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Park Heights ave & Scott St

Former or usual residence 515 Scott St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	Jan 17, 1922
20-UNDERTAKER	ADDRESS
John J Gorman & Son	1 Lee & Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60322 D 60322

CERTIFICATE OF DEATH.

90

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1103 N. Mount St. 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie M. Fletcher

(Residence in Baltimore: No. 1103 N. Mount St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	married

6-DATE OF BIRTH, June 18, 1886.
(Month) (Day) (Year)

7-AGE, 36 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home,
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Phila, Pa.

PARENTS.

10-NAME OF FATHER. George Lewis

11-BIRTHPLACE OF FATHER (State or Country). Delaware

12-MAIDEN NAME OF MOTHER Fannie Butler

13-BIRTHPLACE OF MOTHER (State or Country). Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Fletcher

(Address) 1103 N. Mount St.

15- Robert F. Carrison,
Filed ....., 191.... Registrar.

N 16 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) 9 yrs. mos. ds.

(Signed) J. J. T. Hemmeter, M. D. (Coroner.)

June 15, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 6/16/22 19....

UNDERTAKER 1406 ADDRESS

R. C. Gross McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60323

CERTIFICATE OF DEATH.

129 D 60323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 Cedar Ave. ST., 13 WARD)

2-FULL NAME Aaron Henry

(a) RESIDENCE NO. 3104 Cedar Ave. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Henry

6 DATE OF BIRTH (month, day, and year): July 17-1844

7 AGE — Years: 77 — Months: 5 — Days: 27 — If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shop hand

(b) General nature of industry, business, or establishment in which employed (or employer): Penna. R.R.

(c) Name of employer: Retired 12 years

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Solomon Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Leah Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Wm. F. Henry

(Address): 3104 Cedar Ave

15 Filed ....19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

JAN 6 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Jan 13, 1922 that I last saw him alive on Jan 13, 1922 and that death occurred, on the date stated above, at 7 02 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Heart Died

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Stevenson, M. D.

, 19 (Address) 1632 Rolandene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Jan. 17 1922

UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Hall Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60324 — 31 — D 60324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 638 W. Lombard ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm F. McClean

(Residence in Baltimore: No. 638 W Lombard St St.: 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, May (Month) 29 (Day), 1870 (Year)

7-AGE, 51 yrs. 7 mos. 16 ds. — If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): Furniture

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John McClean

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Comer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Wm McClean

(Address) 3010 McElderry St

15- Robert P. Harrison,

Filed ....., 191.....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N1 01922 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1921, to Jan 14 1922, that I saw h~~e~~ alive on Jan 14 1922, and that death occurred, on the date stated above, at 11 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) B W Kelly M. D.

Jan 14, 1922 (Address) 1200 N Linwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Jan 17, 1922

20-UNDERTAKER George F. Schwab — ADDRESS 1101 Eutaw Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60325

CERTIFICATE OF DEATH.

164 D 60325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 E North Ave. ST.: 17 WARD)

2-FULL NAME Anna M Dorsett

(a) RESIDENCE. No. 416 E North ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Dorsett

6 DATE OF BIRTH (month, day, and year) June 26 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... mins.
	68	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Grace E Bartlett

(Address) 415 E North Ave

15 Filed Robert P. Harrison, Registrar

JAN 16 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1921, to Jan 13 1922,

that I last saw her alive on Jan 13 1922,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities Of Age

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph P. Kemp, M. D.

Jan 16 1922 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	1/18/22

20 UNDERTAKER Engel & Farley ADDRESS Fulton & Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60326

CERTIFICATE OF DEATH.

146 D 60526

REGISTERED NO.....

3-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. N. Broadway ST.: WARD

2-FULL NAME Josephine Warneeker

(a) RESIDENCE. No. 117 N. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Warneeker

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Not known
(State or country) Austria

PARENTS

10 NAME OF FATHER Michael Bloch

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Haeneeker

13 BIRTHPLACE OF MOTHER (city or town) Austria
(State or country)

14 Informant
(Address)

15 Filed JAN 16 1922 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1922, to Jan 14, 1922, that I last saw h-- alive on Jan 14, 1922, and that death occurred, on the date stated above, at 4:24 Pm.

The CAUSE OF DEATH* was as follows:

Puerperal septicemia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Dilatation + curettage for bleeding after spontaneous miscarriage (duration) yrs. mos. seven days ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? Yes Date of 1-10-22

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture

(Signed) Warfield M. Firor, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Swartz Cemetery	Jan 17, 1922

20 UNDERTAKER Wm Cook. ADDRESS 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60327

CERTIFICATE OF DEATH.

X 90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Joseph Lees

(Residence in Baltimore: No. 412 N. Calvert St St.: yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widow

6-DATE OF BIRTH: About ..... (Month), 1860 (Year)

7-AGE: About 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.:

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country): Tennessee

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Barclay

(Address) 703 S. Howard St

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

16 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Organic Heart disease

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. ct. T. Hennessy, M. D.
(Coroner)

Jan. 16, 1922 (Address) 708 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence New York N. Y.

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL, Jany 17, 1922

20-UNDERTAKER F. A. Krause & Son

ADDRESS 703 Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should write carefully supplied. AGE should be stated

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60328

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 N. Belair Road, Overlea ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara C. Harris

(a) RESIDENCE. NO. 600 Belair Road ST. Overlea WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13, 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City, Md.

PARENTS

10 NAME OF FATHER Adam Harris

11 BIRTHPLACE OF FATHER (city or town) Balto. City (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Albaugh

13 BIRTHPLACE OF MOTHER (city or town) Balto. City (State or country) Md.

14 Informant Mrs. Wm. E. Read
(Address) 600 N. Belair Road Overlea

15 Filed , 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

1/16/1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1920, to Jan. 14, 1922, that I last saw h Or alive on Jan. 14, 1922, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

1/16, 1922 (Address) 13 Bel Air Road, Rosedale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	Jan. 17, 1922
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Thomas) ✓

D 60329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60329

CERTIFICATE OF DEATH.

129

6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Jackson Place ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Carlton Thomas

(a) RESIDENCE No. 102 Jackson Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Solicitor (outside/Sales-

(b) General nature of industry, business, or establishment in which employed (or employer) man) 966

(c) Name of employer R. L. Packer Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William C Thomas

11 BIRTHPLACE OF FATHER (city or town) Mathews

(State or country) County, Virginia.

12 MAIDEN NAME OF MOTHER Mary F. Jarvis.

13 BIRTHPLACE OF MOTHER (city or town) Mathews

(State or country) County, Virginia.

14 Informant Mrs Anna C. March

(Address) 102 Jackson Place.

15 Filed 1 6 1922 Registered . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1922.

17

I HEREBY CERTIFY, That I attended deceased from January 10, 1922. to January 15. 1922.

that I last saw him alive on January 15 1922.

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Allen C. Beetham. M. D.

1-15. 1922 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Jan. 19 1922

20 UNDERTAKER ADDRESS

Wm. C. Black 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1531 B 6 D 60330 — 23 D 60330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST.: 7 (Ward) — REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eston O. Mercier Jr.

(a) RESIDENCE. No. 2011 E Eager St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 28th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Eston O. Mercier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ruth Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Eston O Mercier 2011 E Eager Street

15 Filed Jan 18 1922 Robert P. Harrison, Registrar

N1 61922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 13th, 1922, to Jan 16th, 1922, that I last saw him alive on Jan 16th, 1922, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute epidemic encephalitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Horace G. Stewart, M. D.

1/16, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Jan 18 1922

20 UNDERTAKER: William Cook ADDRESS: 502 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60331

CERTIFICATE OF DEATH.

38 D 60331

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 125 W Montgomery ST.: (or WARD) 22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. Read

(a) RESIDENCE. No. 125 W Montgomery ST., 22 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced, HUSBAND of Mamie Read

6 DATE OF BIRTH (month, day, and year) 4/16/1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mamie Read (Address) 125 W. Montgomery St

15 Filed JAN 17 1922 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/14/1922

17 I HEREBY CERTIFY, That I attended deceased from 1/10/22, to 1/14/22, that I last saw h alive on 1/13/22, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (duration) about 6 mos. ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

? Luetic (duration) about yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Smiley, M. D.

1/14/22 19 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Jan 17 1922

20 UNDERTAKER: John W Henderson ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-22 D 60332

D 60332

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1033 N. Calvert ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Bruce Jr.

(Residence in Baltimore: No. 1033 N. Calvert St St.: yrs. mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: January (Month) 1 (Day), 1922 (Year)

7 AGE: ..... yrs. ..... mos. 15 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Howard Bruce

11 BIRTHPLACE OF FATHER (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary Graham Bowdoin

13 BIRTHPLACE OF MOTHER (State or country): Balto-Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Bruce

(Address) 1033 N. Calvert

15

Filed JAN 17 1922 C. H. Grese. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 16 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 16 1922, that I saw him alive on Jan 15, 1922, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. mos. 15 ds

Contributory (SECONDARY) Thrombosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) John Ruhrah M. D.

Jan 16, 1922 (Address) 11 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Family Burial Ground Elkridge Howard Co Md DATE OF BURIAL: 1-17 1922

20 UNDERTAKER: Henry J. Eastman & Sons Co ADDRESS: 1100 Eutaw St. Baltimore Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60333

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

D 60333

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 47bb Park Heights Ave St.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lattie Blanch Elliott

(Residence in Baltimore: No. 47bb Park Heights ave St.; 51 yrs. 0 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Jan 1st (Month) (Day), 1871 (Year)

7-AGE: 51 yrs. 0 mos. 13 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): — 037

9-BIRTHPLACE (State or country): Balto City Md

PARENTS

10-NAME OF FATHER: Charles W. Zuckle

11-BIRTHPLACE OF FATHER (State or country): Balto City Md

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or country): Balto City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John O. Elliott

(Address) 47bb Park Heights ave

15- JAN 17 1922 G. H. Grese.

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan 14 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30, 1921, to, Jan 14 1922, that I saw h.. alive on Jan 14 1922 and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left breast

(Duration) 1 yrs 2 mos. 15 ds.

Contributory (SECONDARY) .....

(Duration) ... yrs ... mos ... ds.

(Signed), John D Zuber M. D.

Jan 16, 1922 [Address] 4884 Park Hgts Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Jan 17th, 1922

20-UNDERTAKER: Chas. Weber & Son

ADDRESS: 2503 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 60334

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Hutchins Road ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Adeline Wofford.

(a) RESIDENCE. No. 426 Hutchinson ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1902.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Govans Md.

PARENTS

10 NAME OF FATHER Richard Wofford.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Emily Wrenn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant M. C. Wofford.

(Address) 426 Hutchins, Govans, Md.

15 Filed JAN 17 1922, 19 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1922

17 I HEREBY CERTIFY, That I attended deceased from 22 Nov, 1921, to Jan 13, 1922, that I last saw her alive on Jan 13, 1922, and that death occurred, on the date stated above, at 12- midnight

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum Exam.

(Signed) H. Longenecker, M. D.

1/14, 1922 (Address) 911 N Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan, 17, 1922
20 UNDERTAKER Samuel T Hensley	ADDRESS W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital REGISTERED NO. 129

CITY OF BALTIMORE: (No. 1213 Light Street ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T Green

(a) RESIDENCE. NO. 2 [illegible] st Street ST. WARD. Brooklyn Md

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isabel A Green

6 DATE OF BIRTH (month, day, and year): Dec 1 1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Benjamin Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaret Ann Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: William T. Green

(Address): 642 N. Fourth Ave.

15 Filed JAN 17 1922 19 G. H. Gresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from December 25, 1921, to January 14, 1922.

that I last saw h.e alive on January 14, 1922.

and that death occurred, on the date stated above, at 12.10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) James Hulbert Wilkerson, M. D.

(Address) South Balto Gen Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Jan 17 1922

20 UNDERTAKER: John F. Denny ADDRESS: 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

D 60336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60336

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

REGISTERED No. C 24179

CITY OF BALTIMORE (No. 205 E. Hamburg Street. St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Olivia A. Starr.

(Residence in Baltimore: No. 205 E. Hamburg St.

St.; yrs. 71 mos. ----- ds. 5.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, January 10th. 1851, / (Month) (Day) (Year)

7-AGE. 71 yrs. --- mos. 5. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. John Hart.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Eva Seipp.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alverta Starr. (daughter).

(Address) 205 E. Hamburg Street.

15-

Filed JAN 17 1922 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 15th. 1922 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the face and body.
Clothes accidentally ignited from coal stove.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

Jan 15th, 1922 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Jan 17 1922
20-UNDERTAKER	ADDRESS
John F. Keany	715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60337 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital St.; 24 WARD) REGISTERED No. C 38

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Le Roy Pearce

(Residence in Baltimore: No. South Baltimore General Hospital St.; ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
32 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boat Builder
(b) General nature of industry, business, or establishment in which employed (or employer): Employer 986

9-BIRTHPLACE, (State or Country), Point Pleasant N J New Jersey

PARENTS.

10-NAME OF FATHER, Frank Pearce

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Mary Pearce

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Marzon M.D.

(Address) South Balto. General Hospital

15- JAN 17 1922

Filed ....., 191.... G. H. Cresse Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 16 1922, to Jan 16 1922, that I saw h[illegible] alive on Jan 16 1922, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

One Hour

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Lues

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Geo. M. Pearce M. D.

1/17, 1922 (Address) 20 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Point Pleasant N J.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Manasquan New Jersey	Jan 18, 1922

20-UNDERTAKER	ADDRESS
John B. Spence	1325 N. Carlton St

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60338

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2119 Monroe ST.: 6 WARD)

2-FULL NAME Frank Gregor

(Residence in Baltimore: No. 2119 Monroe St.; 50 yrs., mos. ds.)

199 D 60338

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar.

6-DATE OF BIRTH, ..., 1870
(Month) (Day) (Year)

7-AGE, 50 yrs. mon. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Oyster
(b) General nature of industry, business, or establishment in which employed (or employer) Schucker

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Joseph Gregor

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Gregor

(Address) 410 N. Chester St.

15-

Filed JAN 1 1922, 191.....

G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Jan 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Edward Adams
Gas. Line explosion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. K. Nuelsen M. D.
(Coroner)

1-16 1922 (Address) 716 Eden,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cem. DATE OF BURIAL, Jan. 17th, 1922

20-UNDERTAKER Philip Herwig ADDRESS 206 Orleans St.

60339

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

1679 60339

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2119 Monroe ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gregor

(Residence in Baltimore: No. 2119 Monroe St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Mal

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Sgle

6-DATE OF BIRTH, ..., 1881
(Month) (Day) (Year)

7-AGE, 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Bottling Helper
(b) General nature of industry, business, or establishment in which employed (or employer) G. B. S. Brewing Co

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Joseph Gregor

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Carpal

(Address) 4110 N. Chester St.

15-

Filed JAN 17 1922, 191... C. H. Cruse
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq
(Inquest, autopsy or inquiry.)
thereon, and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock
Illuminating Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cem.

DATE OF BURIAL, Jan. 17, 1922

20-UNDERTAKER Philip Hennig

ADDRESS 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D 60340

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 110 n Montford ave ST.; WARD) Cave

2-FULL NAME Louisa Coale

(Residence in Baltimore: No. 110 n Montford St.; 3 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 18 (Day) 1905 (Year)

7-AGE, 16 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cashier 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Printing Dept Store

9-BIRTHPLACE, (State or Country), Louisa Va.

PARENTS.

10-NAME OF FATHER, Otto Coale

11-BIRTHPLACE OF FATHER (State or Country), Va-

12-MAIDEN NAME OF MOTHER Bertha B-

13-BIRTHPLACE OF MOTHER (State or Country), Va-

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha B. Krug

(Address) 110 N. Montford Ave.

15-

Filed JAN 17 1922, 191.... G. H. Gray Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Bichloride

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

1-16-22, 191.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Jan 18th, 1922

20-UNDERTAKER Philip Herwig

ADDRESS 206 Orleans St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60341

90 D 60341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 N. Linwood St. 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Doering

(a) RESIDENCE. No. 444 N. Linwood ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Geo. A. Doering

6 DATE OF BIRTH (month, day, and year) July 10. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Borgmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Christina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Geo A Doering
(Address) 444 N. Linwood al

15 Filed JAN 17 1922, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6. 1921. to Jan 15. 1922.

that I last saw h-- alive on 1 15 1922

and that death occurred, on the date stated above, at 4 30 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? --- Date of

Was there an autopsy? ---

What test confirmed diagnosis? Clinical

(Signed) A. B. Keane M. D.

1/16. 1922 (Address) 2600 Eldorado

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	1/19 1922
20 UNDERTAKER Philip Herring	ADDRESS 2016 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ODONTPA... TION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Bks.

D 60342

HEALTH DEPARTMENT—CITY OF BALTIMORE

109 D 002 60342

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3140 Elmora ave ST., 8 WARD)

2-FULL NAME John R. Esley

(a) RESIDENCE NO. 3140 Elmora ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Esley

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45	3	7	

8 OCCUPATION OF DECEASED Painter 150
(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles T. Esley

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Bertie Keith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary E. Esley
(Address) 3140 Elmora Ave

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from December 3, 1921, to January 15, 1922, that I last saw him alive on January 14, 1922 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) H. Outten Sinnard, M. D.

1/16, 1922 (Address) 1613 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Jan 18 1922
20 UNDERTAKER Funkler & Funkler E.J.F.	ADDRESS 1217 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Brooklyn, Md.

CITY OF BALTIMORE: (No. ST., 25 WARD)

REGISTERED NO. 161 D 60343

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kearns

(a) RESIDENCE No. 506 Patapsco Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16th, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER R. E. Kearns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence V. Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant R. E. Kearns (Address) 506 Patapsco ave.

15 Filed JAN 17 1922 J. C. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16th 19 22

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. A. Brooke, M. D.

Jan 17 1922 (Address) Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick Texas Mod	1-19 1922

20 UNDERTAKER Margaret G. Flynn ADDRESS 1417 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60344

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 60344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N Durham ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin H. Lane

(a) RESIDENCE NO. 18 N Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	1	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm B Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Cox.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm C. Lane

(Address) 130 Belnord Ave

15 JAN 17 1922 Filed , 19 E.H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 19 22 to Jan. 19, 19 22

That I last saw h alive on Jan. 13, 19 22

and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) — yrs. — mos.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No clinical finding

What test confirmed diagnosis?

(Signed) M. Helmin, M. D.

, 19 (Address) 3 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Jan 19 22

20 UNDERTAKER J Kerney & Co

ADDRESS 200 Block

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60345

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 Wabbrook Ave ST.: 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Baumgarten

(a) RESIDENCE. No. 2816 Walbrook Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Catonsville Md.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant W F Baumgarten
(Address) 2816 Walbrook Ave

15 Filed ... , 19 1922 H Ellehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2-4 1920 to Jany 16th 1922 that I last saw h[illegible] alive on Jany 14th 1922, and that death occurred, on the date stated above, at 4 20 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an aperation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W F Fair, M. D.

1/16 1922 (Address) 12 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 18 1922

20 UNDERTAKER George J Smith ADDRESS 1000 W Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60346

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1472 Woodall St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Blackeby.

(Residence in Baltimore: No. 1472 Woodall St.

42 -- 11 -- 9.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, February 6th, 1879. / (Month) (Day) (Year)

7-AGE. 42 yrs. 11 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Glass bottle
(b) General nature of industry, business, or establishment in which employed (or employer): packer.

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Joseph Blackeby.

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER. Mary Phillips.

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Blackeby.(wife).

(Address) 1472 Woodall Street.

15-

JAN 17 1922

Filed ....., 191.... C. H. Grese.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 15th, 1922. 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. M. Reinhardt M. D.

Jan 15th, 1922. 191... (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland Cem. DATE OF BURIAL, Jan. 17, 1922

20-UNDERTAKER Margaret G. Flynn ADDRESS 14 N. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60347

CERTIFICATE OF DEATH.

90 D 60347

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Tamalions

(a) RESIDENCE No. 127 W. Camden St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joe Chewak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Hospital Records, Municipal Hospital

15 Filed [illegible], 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 14 1922

17 I HEREBY CERTIFY, That I attended deceased from December 19, 1921, to January 14, 1922, that I last saw h i alive on January 14, 1922, and that death occurred, on the date stated above, at 12 M. N. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde M. Reed, M. D.

1/16/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 18 1922
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 60348 — 129 — D 60348

PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1724 Poplar Grove St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Edwin Romoser

(Residence in Baltimore: No. 1724 Poplar Grove St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): M

6 DATE OF BIRTH: June (Month) 5 (Day), 1864 (Year)

7 AGE: 57 yrs. 7 mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Plumber 059
(b) General nature of industry, business, or establishment in which employed (or employer): United Railway Co.

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Charles Phillips Romoser

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Daily

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence J. Romoser
(Address) 1724 Poplar Grove St.

15
Filed JAN 17 1922 191
G. H. Grese. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jany (Month) 16 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 3 years ago T. 191 . to. Jan 15 1922, that I saw h[im] alive on Jan 15 .1922, and that death occurred, on the date stated above, at 7.10 a m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(Duration) 3 1/2 yrs. mos. ds

Contributory (SECONDARY) Uraemia

(Duration) yrs. mos. 7 ds.

(Signed) Barnett Colton M. D.

1/20, 1922 (Address) 1404 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Jan 18th 1922

20 UNDERTAKER: Wilbur W Shriver — ADDRESS: 1118 Edmondson Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60349

CERTIFICATE OF DEATH.

101 001 D 60349

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Arisquith ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel [illegible] Grossman

(a) RESIDENCE. NO. 517 N. Arisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed.

5a If married, widowed, or divorced
~~WIFE of~~ HUSBAND of Tillie Grossman.

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) — (State or country) Roumania

PARENTS

10 NAME OF FATHER Morris Grossman

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Roumania

12 MAIDEN NAME OF MOTHER Yetta Grossman

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Roumania

14 Informant Sarah Singer
(Address) 609 S Greene St.

15 Filed . 19 Registrar
JAN 17 1922 G. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 16 1922

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1922, to January 16, 1922, that I last saw him alive on January 15, 1922, and that death occurred, on the date stated above, at 10:00 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) none
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? none Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) Chester Reland, M. D.

1-16, 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Int. Cop Hebron	Jan 17 1922
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60350

CERTIFICATE OF DEATH.

90 D 60350

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N. Gelmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jamie M. Knoots.

(a) RESIDENCE. No. 109 N. Gelmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Knoots

6 DATE OF BIRTH (month, day, and year) Jan 2 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Pvt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Otha Reel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Catherine Haine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick

14 Informant Clara J. Hynn

(Address) 709 N. Gilmor St

15 Filed , 19 Registrar

JAN 17 1922 C. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from During, to Jan 16 1921, that I last saw her alive on Jan 15, 1922 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

DTW

Cardiac Asthma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Kennedy, M. D.

Jan 16 1922 (Address) 34 So Dallas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 18 1922

20 UNDERTAKER Wm Good & Co

ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Mitral Regurgitation
for years

Spec.—1-10-21—M&T—1500 Bks.

Dr. Cor.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60351

CERTIFICATE OF DEATH.

D 60351

179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 James St. Ward 26 ST., ... WARD)

2-FULL NAME Margaret Schultheis.

(a) RESIDENCE NO. 2210 James St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Paul Schultheis.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Geo Metzler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know.

14 Informant Rose Dressell.
(Address) 810 Columbia Ave

15 Filed JAN 17 1922, 19.. G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 15, 1922.

that I last saw her alive on Jan 15, 1922.

and that death occurred, on the date stated above, at 5 15 m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wallace A Cox, M. D.

1-17, 1922 (Address) 547 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Jan 18 1922

20 UNDERTAKER Wm Cook — ADDRESS 502 E. Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60352

161 D 60352

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1623 N Dallas St ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME x

(a) RESIDENCE. No 1623 N Dallas st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	All	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of x

6 DATE OF BIRTH (month, day, and year) Jan 15-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1/22	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work x

(b) General nature of industry, business, or establishment in which employed (or employer) x

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Julian Watson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Benjamin Brown
(Address) 1623 N Dallas st

15 Filed JAN 17 1922 19 G. H. Crose. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1922, to Jan 15, 1922, that I last saw h... alive on Jan 15 1922 and that death occurred, on the date stated above, at 1 p a m.

The CAUSE OF DEATH* was as follows:

premature Birth
and Syphilis Congenital
Infection of the Mother

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis Congenital

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? x Date of x

Was there an autopsy? x

What test confirmed diagnosis? x

(Signed) G. Hall M. D.

19 (Address) 1726 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Jan 18 1922

20 UNDERTAKER Robert A Elliott ADDRESS 1726 Ashland Ave

TION is very important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPA- ... in plain terms, so that it ... State

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60353

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101 D 60353

CERTIFICATE OF DEATH

1-PLACE OF DEATH Robt Garrett Hosp for Children REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N. Carey ST.: ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Roberts

(a) RESIDENCE. NO. Chesco Park Md ST., ... WARD. ...
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co

PARENTS

10 NAME OF FATHER Clarence E Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ida Wickenford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Ida Roberts
(Address) Chesco Park Md

15 Filed JAN 17 1922 G. H. Gresc Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th 1921, to Jany 15 1922, that I last saw him alive on Jany 15 1922, and that death occurred, on the date stated above, at 10 55 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Flaccid Paralysis (duration) ... yrs. ... mos. 6 weeks

Amyotonia Congenita

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. H. V. Cluff M. D.

1/15, 1922 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 17 1922

20 UNDERTAKER F. A. Fransen & Son ADDRESS 703 Hanover

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 60354

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60354

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 S. Stricker ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Personette

(a) RESIDENCE NO. 333 S. Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 77 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Personette

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mary Wilkes

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Mrs. Geo. Gilmore

(Address) 333 S. Stricker St.

15 Filed JAN 17 1922 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-15 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1922 to Jan 15, 1922, that I last saw h[illegible] alive on Jan 15, 1922 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) [illegible], M. D.

1/17, 1922 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Jan [illegible] 1922

20 UNDERTAKER John J. Fields ADDRESS 200 N. Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60355

CERTIFICATE OF DEATH.

46 D 60355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 N. Fulton Ave. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A. Blattau.

(a) RESIDENCE NO. 9 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Blattau.

6 DATE OF BIRTH (month, day, and year): Dec 14 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hellsburg. W. Virginia

PARENTS

10 NAME OF FATHER: John Pickelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary B. Eddmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Wm. Neidhardt. 215 Freeway Apartments.

15 Filed JAN 17 1922 C. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1921, to Jany 15, 1922, that I last saw h[illegible] alive on Jany 15, 1922, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Incurable Carcinoma cerat.

2. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo. Kalternn M. D.

(Address) 345 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer Cem	Jany 19" 1922
20 UNDERTAKER	ADDRESS 2336
Wm J Hartnett	W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60356 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60356

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 N. Lakewood Ave. 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Darmsteadt.

(a) RESIDENCE No. 429 N. Lakewood Ave ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Darmsteadt.

6 DATE OF BIRTH (month, day, and year) Jan. 6th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Potter at Bennetts

(b) General nature of industry, business, or establishment in which employed (or employer): Pottery 086

(c) Name of employer: Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Pheley Darmsteadt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Regina Bartholomay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Darmsteadt.
(Address) 429 N. Lakewood ave.

15 Filed ..... 19 Registrar.

JAN 17 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1921. to Jan. 15, 1922.

that I last saw him alive on Jan. 14, 1922.

and that death occurred, on the date stated above, at 11 15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Passano, M. D.

Jan. 16, 1922 (Address) Ten Hills Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Redeemer Cemetery Jan 18 1922

20 UNDERTAKER — ADDRESS

Lilly & Zeiler 403 S. Wolfe

TION is very important. See instructions on back of certificates.

Spec. 5-9-19—M. B. Co.—100m Bks.

D 60357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 60357

1-PLACE OF DEATH South Balto. General Hospital

REGISTERED NO. 111-001

CITY OF BALTIMORE: (No. 1213 S. Light St. ST.: | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Mason

(a) RESIDENCE: No. 806 S. Port Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mason

6 DATE OF BIRTH (month, day, and year) December 8-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Federal Tin Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn N. Y.

12 MAIDEN NAME OF MOTHER Annie E. Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary A. Mason (Address) 806 S. Port St.

15 Filed JAN 17 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1922, to Jan. 15, 1922, that I last saw him alive on Jan. 15, 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer OVER

(duration) yrs. mos. 15 ds.(?)

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 12, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) Carl F. Benson, M. D.

. 19 (Address) South Balto. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Cem.	Jan 19, 1922
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Mat'l Av

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant.

D 60358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60358

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 915 N. Caroline ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula Long

(Residence in Baltimore: No. 915 N. Caroline St.: 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	married

6-DATE OF BIRTH, June 5 (Month) (Day), 1898 (Year)

7-AGE,	If LESS than 1 day,
23 yrs. 7 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. William Talen

11-BIRTHPLACE OF FATHER (State or Country). N. C.

12-MAIDEN NAME OF MOTHER Louisa Tyler

13-BIRTHPLACE OF MOTHER (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Long

(Address) 915 N. Caroline St.

15-

Filed ....., 191.. Registrar.

71922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 14 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and jury find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart. 5 minutes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis 20 minutes

(Duration) yrs. mos. ds.

(Signed) J. T. Kearney M. D. (Coroner.)

Jan. 17, 1922 (Address) 1023 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Berkley, Norfolk Co, Va.

DATE OF BURIAL, Jan. 17, 1922

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Etting St.

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 60359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60359

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S. 1st St. Brooklyn ST., 25 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — baby — Howard

(a) RESIDENCE No. 215 S. 1st St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 15/22

7 AGE	Years	Months	Days	If LESS than 1 day, 8 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER Solon Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co. Md.

12 MAIDEN NAME OF MOTHER Jenera Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Jenera Howard

(Address) 215 S. 1st St. Brooklyn

15 Filed 1 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1922, to Jan 15, 1922.

that I last saw him alive on Jan 15, 1922,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis 8 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Geo. B. Davis M. D.

1/15, 1922 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Furnace Branch A.A.Co. DATE OF BURIAL: Jan 17 1922

20 UNDERTAKER: John F. Denny ADDRESS: 715 Light

TION is very important. See instructions on back of certificates.

may be properly classified. Exact statement of OCCUPA-

DEATH in plain terms, so that it

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60360

CERTIFICATE OF DEATH Clara Overman

D 60360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp St. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Overman

(a) RESIDENCE NO. 1117 Somerset ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank Overman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Caroline Overman

(Address) 1117 Somerset St

15 Filed Jan 19 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1922 to Jan 16 1922

that I last saw her alive on Jan 15, 1922

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman J. Dorf, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 18 1922

20 UNDERTAKER	ADDRESS
Henry Storck Son	130 E Eager St

TION is very important. See instructions on ... may be properly classified. Exact statement of OCCUPA- ... on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60361 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60361

57

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 E. Preston ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Rosenberger

(a) RESIDENCE NO. 1725 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. A. Rosenberger

6 DATE OF BIRTH (month, day, and year) not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 62	-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Neumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Rosenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Wm. A Rosenberger

(Address) 1725 E Preston St

15 Filed ..., 19 Robert F. Carrick, Registrar

Burial Permit Clerk.

17032

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 9 1922 to Jan. 16 1922

that I last saw h E V alive on Jan. 16 1922

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Saylor M. M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan. 19 1922

20 UNDERTAKER	ADDRESS
Henry Hoerle Son	130 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60362

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 1 ST.: 5 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Euada Mosley

(a) RESIDENCE. No. 1056 Lost ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3, SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed 1 7 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9 1922

17 I HEREBY CERTIFY, That I attended deceased from 1-7, 1922, to 1-9, 1922, that I last saw h[illegible] alive on 1-9, 1922, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

Practically instantaneous
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency-7 weeks
Aortic insufficiency (duration) yrs. mos. ds.
Syphilis unknown duration

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No Physical examination

What test confirmed diagnosis? and Wassermann pt

(Signed) Francis R. Dieudonne, M. D.

Jan. 9, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

18819

JAN 7 1922

Commissioner Health.

Wm. F. WOOSALL.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60363

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gurry.

(a) RESIDENCE NO. 1121 Person. Ave, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8, 1922

7 AGE — Years: — Months: — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert Talbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Bessie Gurry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital

15 Filed , 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922 to Jan 9, 1922

that I last saw her alive on Jan 9, 1922

and that death occurred, on the date stated above, at 8.00 p. m.

The CAUSE OF DEATH* was as follows:

Premature
Atelectasis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. H. Cathrall M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: JAN 13 1922, 19

20 UNDERTAKER: Commissioner Health;

ADDRESS

Post. Wm. H. Neukirk

TION is very important. See instructions on back of certificates.

that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60364 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60364

CERTIFICATE OF DEATH.

REGISTERED NO. 162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 N. Lanvale. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Warner.

(a) RESIDENCE. No. 638 N. Lanvale. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 11-1921

7 AGE Years Months Days If LESS than 1 day 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. Chas. Warner.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Martha Jardinka

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country) New York.

14 Informant
(Address)

15 Filed JAN 17 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1922, to Jan. 12, 1922, that I last saw h.e alive on Jan. 12, 1922, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged labor.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) L. J. Rigney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	JAN 19 1922 19
20 UNDERTAKER	ADDRESS

Robert P. Harrison
Commissioner Health.
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60365 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60365

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 12 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Raymond Edwards

(a) RESIDENCE. No. 1809 Maryland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Francis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge, Maryland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed JAN 17 1922, 19 Robert F. Harrison, Registrar

Burial Permit 15828

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from December 29 1921. to January 12 1922.

that I last saw him alive on January 12 1922.

and that death occurred, on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous epididymitis; miliary tuberculosis; tuberculous meningitis

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis; C.S. Syphilis.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/12/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS
Commissioner Health,	JAN 17 1922

TION is very important. See instructions on back of certificates. ...ck be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60366 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60366

CERTIFICATE OF DEATH. 113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S. Charles ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Allen Avery

(a) RESIDENCE. NO. 206 S Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov 12th 21

7 AGE — Years: — Months: 1 Days: 19 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Ernest Avery

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: [illegible]
(Address): [illegible]

15 Filed JAN 17 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 19 21, to Jan 15th, 19 22, that I last saw h[illegible] alive on Jan 14th, 19 22, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Jan 17, 19 22 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health. — ADDRESS: JAN 17 1922

per Wm. E. WOODALL

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

...n may be properly classified. Exact statement of OCCUPA-

Spec. 6-9-19—H. P. Co.—1000 Bks.

(Powders)

D 60367 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60367

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 328 Colon's St. 5 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ponders

(a) RESIDENCE. No. 328 Colons St' ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord'	Marrd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborr' 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mary Deane' (Address) 328 Colonse

15 Filed Robert P. Harrison, Registrar

N171922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan-4, 1922, to Jan 17, 1922 that I last saw him alive on Jan 16, 1922 and that death occurred, on the date stated above, at 330 a' m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis? Symptoms

(Signed) W. K. Council M. D.

, 19 (Address) 117 W Dallas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 19 1922

20 UNDERTAKER ADDRESS

Clement Hall 909 Hillen St

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—2000 Bks.

D 60368

HEALTH DEPARTMENT—CITY OF BALTIMORE

Jak. 006
HK Gorsuch
Connor. W D

CERTIFICATE OF DEATH. D 60368

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Jewell

(a) RESIDENCE. No. 881 W. Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilby H. Jewell

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Water tender 086

(b) General nature of industry, business, or establishment in which employed (or employer) Terminal Freezing & Heating Co

(c) Name of employer Terminal Freezing & Heating Co

9 BIRTHPLACE (city or town). (State or country) Virginia

PARENTS

10 NAME OF FATHER John Jewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Attending Phys. records.
(Address)

15 Filed JAN 17 1922 19 E Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1922, to Jan. 16, 1922, that I last saw him alive on Jan. 16, 1922 and that death occurred, on the date stated above, at 5:15 a m.

The CAUSE OF DEATH* was as follows:

Traumatic rupture of spleen

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Terminal Freezing and Heating Co

Did an operation precede death? NO Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) ... H W Jordan, M. D.

1/16. 1922 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem Frederick Md	Jan 18 1922
20 UNDERTAKER	ADDRESS
Daniel Easton	Fred

TION is very important. See instructions on back of certificates.

D 60369 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 100-002 D 60369

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 627 W Mulberry ST.: 4 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Nelson E Smith

(Residence in Baltimore: No. 627 W Mulberry St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE, 28 Days yrs. mos. 28 dys.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Mr Smith

11-BIRTHPLACE OF FATHER (State or Country). S. C.

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country). S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Eastern

(Address) 96 Penn

15-

Filed ..... 191.. H Wellen Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Cold

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) H. E. Lennon M. D. (Coroner.)

1-17, 1922 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Jan 19 1922

20-UNDERTAKER David Eastern — ADDRESS 96 Penn

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60370

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 E. Preston ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Rosen Schulte

(a) RESIDENCE. NO. 908 E Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Frank Schulte

6 DATE OF BIRTH (month, day, and year) Dec. 18. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Carano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie F Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank Schulte
(Address) 908 E. Preston St.

15 Filed 1 7 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1922.

17 I HEREBY CERTIFY, That I attended deceased from 1/20/1917, 19, to 1/17/22, 19, that I last saw her alive on 1/16/22, 19, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) H. W Gaddess, M. D.

1/17/22, 19 (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem.	Jan. 19 1922
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	1944 W. Nordhan

IT IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Cu.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60371

D 60371

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 N. Fakewood ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M Hooker

(a) RESIDENCE. No. 1401 N. Fakewood ST., 6 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Benson Hooker

6 DATE OF BIRTH (month, day, and year): June 22-1866

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
55	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10 NAME OF FATHER: Adam Eisenhauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): German

12 MAIDEN NAME OF MOTHER: Margaret Dobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George Horner
(Address): 1401 N. Fakewood Ave

15 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/15 19 22

17 I HEREBY CERTIFY, That I attended deceased from 12/10 19 21, to 1/15 19 22

that I last saw h alive on 1/15 19 22

and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cellulitis of Face

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1/16/22 (Address) 1639 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	1-18-22

20 UNDERTAKER: C. A. Moran

ADDRESS 3000 E Baltimore

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

(Sauter)

D 60372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60372

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 4301 St Paul ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lost Sautro

(a) RESIDENCE NO 4301 St Paul ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 8 1868

7 AGE — Years: 53 Months: 9 Days: 6 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Sauter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Agatha Schady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Harry C. Sauter (Address): 4301 St Paul

15 Filed 1922 Robert F. Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany 13, 1922, to Jany 16, 1922, that I last saw him alive on Jany 15, 1922 and that death occurred, on the date stated above, at 5-15 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

About 6 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fehlings + Benedicts Dr J B Fulcher in consultation

(Signed) A C Pole, M. D.

, 19 (Address) 2032 E Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Jan 19 1922

20 UNDERTAKER: J C Bassford Jr — ADDRESS: Baltimore

IMPORTANT. See instructions on back of certificates. Exact statement of occupation may be properly classified. State

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60373

CERTIFICATE OF DEATH.

1922

D 60373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 Edgewood ST., 16 WARD)

2-FULL NAME Thomas Eldridge Stevens

(a) RESIDENCE NO. 624 Edgewood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna M. Stevens

6 DATE OF BIRTH (month, day, and year) June 2 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Owner

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Richard T. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs T. Stevens

(Address) Annapolis Rt 1 Balto Co.

15 Filed Jan 17 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17

I HEREBY CERTIFY, That I attended deceased from January 8, 1922, to January 16, 1922,

that I last saw h[illegible] alive on Jan 16, 1922,

and that death occurred, on the date stated above, at 6,50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 1 yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Place of Birth

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) [illegible] M. D.

Jan 18, 1922 (Address) 501 Cleveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Jan 18 1922

20 UNDERTAKER Wm Wickersham

ADDRESS North Ave

IMPORTANT.—Name of DECEASED in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60374

71-002

D 60374

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 E Lafayette ST., 8 WARD)

2-FULL NAME Catherine R. Jones

(a) RESIDENCE NO. 2106 E Lafayette ST., ..WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of child.

6 DATE OF BIRTH (month, day, and year) Sept. 28. 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Gentry.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know.

12 MAIDEN NAME OF MOTHER Viola Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Viola Jones.

(Address) 2106 E Lafayette.

15 1-7-1922 Robert P. Harrison, Registrar

Asst. Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1921, to Jan 15, 1922.

that I last saw her alive on Jan 15, 1922.

and that death occurred, on the date stated above, at 12.50 P m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Cerebrospinal Meningitis

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Acute Interstitial Nephritis (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Albert Za Hesser M. D.

Jan 16 1922 (Address) 1621 N Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Jan 20 1922.

20 UNDERTAKER ADDRESS

McCook & E Main

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60375 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60375

CERTIFICATE OF DEATH.

49 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen Hospt. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Octavia Dix

(a) RESIDENCE. No. 403 Whitridge Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Alice Dix

6 DATE OF BIRTH (month, day, and year) Aug 4-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Weigher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frankliintown Md

PARENTS

10 NAME OF FATHER Isaac Dix

11 BIRTHPLACE OF FATHER (city or town) (State or country) at Sea

12 MAIDEN NAME OF MOTHER Rebecca M Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Alice H. Dix
(Address) 403 Whitridge

15 Filed , 19 . Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-17 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/27/21, 19 , to 1/17/22, 19 , that I last saw him alive on 1/17/22, 19 , and that death occurred, on the date stated above, at 7:10 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

over

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? yes

What test confirmed diagnosis? Microscopic

(Signed) J. Tompkins, M. D.

, 19 (Address) Md Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Reamden	1/19 1922
20 UNDERTAKER	ADDRESS
William Cook	502 E Fort

IMPORTANT is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 60376

HEALTH DEPARTMENT—CITY OF BALTIMORE

74,001

D 60376

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 E. Fort Ave. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Wolgast

(a) RESIDENCE. No. 135 E. Fort Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wolgast

6 DATE OF BIRTH (month, day, and year) Oct. 4 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Korbein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna K. Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna K. Rubenstein
(Address) 135 E. Fort Ave.

15 Filed . 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1, 17 1922

17 I HEREBY CERTIFY, That I attended deceased from 12. 10. 1919 to 1. 17 1922

that I last saw h— alive on 1. 17 1922

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Old Age's Previous attack

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gasped Breathing

(Signed) J. Darlington, M. D.

1/7 1922 (Address) 102 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ridgewood N. J.	1/19 1922
20 UNDERTAKER	ADDRESS
I. Fau McCully	1100 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60377 X 46 D 60377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jane Quinn

(a) RESIDENCE. No. Howard A. Kelly Hospital WARD Sulphur Springs Tenn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matthew D. Quinn

6 DATE OF BIRTH (month, day, and year) May 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Matthew Edmonson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Elizabeth Duncan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant S. E. Quinn (Address) Johnson City Tenn

15 Filed ... 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1922 to Jan 17, 1922 that I last saw h[e] alive on Jan 17, 1922 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovaries

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Post operative anuria.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 10 1922

Was there an autopsy? No

What ~~was~~ confirmed diagnosis? Anuria

(Signed) Dudley A Kabrick, M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sulphur Springs Tenn R. R. Burlington Jonesboro Tenn	Jan 17 1922

20 UNDERTAKER ADDRESS

Chas. S. Black 742 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 60378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60378

CERTIFICATE OF DEATH.

REGISTERED NO. 43

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1815 N. Pulaski ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Anderson

(a) RESIDENCE NO. 1815 N. Pulaski ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 58				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS
10 NAME OF FATHER Joshua Anderson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Sarah Stanford
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Elizabeth Anderson
(Address) 1815 N. Pulaski

15 Filed 7 1922, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1922

17 I HEREBY CERTIFY, That I attended deceased from 1900, 1900, to Jan 16, 1922, that I last saw him alive on Jan 14, 1922, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of tongue and throat

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Stranulation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? microscope

(Signed) C. T. Gabriel, M. D.
, 19 (Address) 2413 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park
DATE OF BURIAL 1/18 1922

20 UNDERTAKER William Cook
ADDRESS 5026 York

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 60379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159 D 60379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 W. Fairmount St.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C Meyd

(a) RESIDENCE. NO. 2520 W Fairmount St. Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank J Meyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliz A Nickles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank J Meyd.
(Address) 2520 W Fairmount Ave

15 Filed JAN 18 1922 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921, to Jan 16, 1922, that I last saw her alive on Jan 14, 1922, and that death occurred, on the date stated above, at .m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia
Congenital Heart Disease

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Edw C Coolahan, M. D.

1/17 1922 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Some Reunited 2168	Jan 19 1922
20 UNDERTAKER	ADDRESS
M. Doyle &	15 E. Lee St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60380 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 123 D 60380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Price

(a) RESIDENCE. No. 1201 Etting St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1861?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 ?	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West River, Indiana

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed JAN 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 14 1922

17

I HEREBY CERTIFY, That I attended deceased from January 5, 1922 to January 14, 1922.

that I last saw him alive on January 14, 1922.

and that death occurred, on the date stated above, at 10:35 P.M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Surg.

(Signed) Clyde A. Reed, M. D.

1/16/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 18 1922
20 UNDERTAKER	ADDRESS 142 W Fell St
John H. Toadvine	

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60381

CERTIFICATE OF DEATH.

D 60381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 McCulloh ST.; 14 WARD)

REGISTERED NO. C 118

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E Winston

(Residence in Baltimore: No. 1828 Mc Culloh St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ...(Month) ....(Day) 1868 (Year)

7-AGE, 54 ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Georgell Briggs

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriett Dorsey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Winston

(Address) 1828 Mc Culloh St

15-

Filed ....., 191.....

JAN 18 1922 G. H. Gress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 14 1922, to Jan 16 1922, that I saw h[illegible] alive on Jan 13 1922, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

Cardiac Dilatation

(Duration) 4 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ....yrs. ....mos. 2 ds.

(Signed) J. H. Anderson M. D.

Jan 18 1922 (Address) 1201 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ft Auburn — DATE OF BURIAL, Jan 18 1922

20-UNDERTAKER Samuel T Kennedy — ADDRESS 578 N Eutaw St

Important. See instructions on back of certificate. Also statement of OCCUPATION very

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60382

CERTIFICATE OF DEATH.

90 D 60382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Peach alley St. 23 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas

(a) RESIDENCE No. 1014 Peach alley City WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Thomas

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 yrs.		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Adam Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Ella Thomas wife (Address) 1014 Peach alley

15 Filed JAN 18 1922 . 19 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 16 " 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1" 1921 to Jan. 16 1922 that I last saw him alive on Jan. 15" 1922 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Mitral Insufficiency

(duration) yrs. 2 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. L. Shelton, M. D.

1/16, 1922 (Address) 203 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Jan 18" 1922

20 UNDERTAKER: Samuel F. Lemmon ADDRESS: 578 N Bidle St

TION is very important. See instructions on back of certificates. ...may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21 M&T 1500 Bks.

D 60383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60383

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1345 N. Calhoun ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willing Lapy Richardson

(a) RESIDENCE NO. 1345 Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mihria Richardson

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years 37 Months Days If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter Col

(b) General nature of Industry, business, or establishment in which employed (or employer) Public institution

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Willis Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Billings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mihria Richardson (Address) 1345 N. Calhoun St

15 Filed JAN 18 1922, 19 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1921, to Jan 16, 1921, that I last saw her alive on Jan 16, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Duration yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) R. Gaul Chrisman M. D.

(Address) 1334 E. N. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 18th 1922

20 UNDERTAKER Samuel Kennedy — ADDRESS 578 E. Fayette

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 60384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60384

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST. WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Myrtle E Becker

(Residence in Baltimore: No. 1117 Ward St, St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Aug 22, 1896 (Month) (Day) (Year)

7-AGE. 25 yrs. 4 mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country). Balt Md

PARENTS.

10-NAME OF FATHER. Clinton Carter

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Miss Stubbs

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Becker

(Address) 1117 Ward St

15-

Filed JAN 18 1922 191.....

G. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1922, to Jan 15 1922 that I saw her alive on Jan 15 1922 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Pneumococcus (Duration) ...yrs. ...mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) ...yrs ...mos. 5 ds.

(Signed) H. C. Worrick M. D.

Jan 18, 1922 (Address) Franklin Sq. Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? At home.

Former or usual residence 1117 Ward St. City

19-PLACE OF BURIAL, OR REMOVAL, Mount Olivet Cemetery

DATE OF BURIAL. Jan 18, 1922

20-UNDERTAKER Geo Limbach & Son

ADDRESS 617 N Howard

Important. See instructions on back of certificate.

D 60385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60385
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 627 N. Calhoun ST.: 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B.)

2-FULL NAME Samuel N. Chairs

(Residence in Baltimore: No. 627 N. Calhoun St. St.: 11 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: July 25 (Month) (Day), 1857 (Year)

7-AGE: 54 yrs. 5 mos. 20 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired 186
(b) General nature of industry, business, or establishment in which employed (or employer): farmer

9-BIRTHPLACE, (State or Country): U. A. Co. Md

PARENTS.

10-NAME OF FATHER: Franklin Chairs

11-BIRTHPLACE OF FATHER (State or Country): U. A. Co. Md

12-MAIDEN NAME OF MOTHER: Maria P. Walker

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M. Chairs

(Address) 627 N. Calhoun St.

15-

Filed ..... 191.....

JAN 18 1922

C. H. Cross
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 15, (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Dilatation of Heart
5 months
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Ac. Gastro Enteritis
3 days
(Duration) yrs. mos. ds.

(Signed) J. A. Hennessy M. D.
(Coroner.)
Jan. 16, 1922 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Jany 18 1922

20-UNDERTAKER: John O. Mitchell ADDRESS: 1208 E. Fayette St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60386

CERTIFICATE OF DEATH.

161 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2940 Cedar Ave ST.) 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred C. Bressler

(a) RESIDENCE. NO. 2940 Cedar Ave, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 9, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md,

PARENTS

10 NAME OF FATHER Edw E. Bressler

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Co, Pa,

12 MAIDEN NAME OF MOTHER Mildred Whittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md,

14 Informant Edw. E. Bressler.
(Address) 2940. Cedar ave

15 Filed ..., 19 ...
Registrar

JAN 18 1922 G. H. Crese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1922, to Jan 17, 1922,
that I last saw her alive on Jan 17, 1922,
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:

Inanition

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W. Elliott, M. D.

1/18 1922 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Jan. 19 22
20 UNDERTAKER	ADDRESS
J. Walter Davis	330 N Pine St

FOR is very important. See instructions on back of certificates. May be properly classified. Exact statement of OCCUPA-

Spec. 1-10-21 M&T 1500 Bks.

D 60387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60387

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 11 N. Ann ST., 6 WARD)

2-FULL NAME Jacob Schiff

(a) RESIDENCE NO. 11 N. Ann ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mon. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Schiff

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1411 E. Balto. St.

15 Filed JAN 18 1922 19 C. H. Green Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1922, to 1922, that I last saw him alive on Jan 16 1922, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

many years

(duration) several (?) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Lewis, M. D.

Jan 17, 1922 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Rosedale	1/18 1922
20 UNDERTAKER	ADDRESS
Jack Levin	1411 E. Balto St.

CAUSE OF DEATH should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 60338

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital St. 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Samuel Rosenbloom

(Residence in Baltimore: No. 36 N Eden St

8 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) M

6-DATE OF BIRTH, Dec 1 (Month) (Day), 1 (Year)

7-AGE, 68 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Clothing
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Asreal Rosenbloom

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dinkens

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Baltimore St

15-

Filed JAN 18 1922, 191.... Registrar.

C. H. Cressey

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 17 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Intoxication (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. J. Neeley M. D.
(Coroner)

1-18, 1922 (Address) 7 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Workmens circle Cem DATE OF BURIAL, Jan 21, 1922

20-UNDERTAKER Jack Levis ADDRESS 1411 E Baltimore St

IMPORTANT: DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Dr. Wm. A. B. Sellman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2112 Barclay St

CITY OF BALTIMORE: (NO. ..... ST.; 12 WARD)

1912 D 60389

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward A Dugan

(Residence in Baltimore: No. 2112 Barclay St ..... St.; 12 yrs., 6 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~Single~~ MARRIED, WIDOWED, OR DIVORCED. (~~Write~~ the word.)

6-DATE OF BIRTH, January 18, 1897 (Month) (Day) (Year)

7-AGE, 5 1 yrs. 6 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Telegraph Messenger Boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Edward Dugan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Conway

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Dugan

(Address) 2112 Barclay St

15-

Filed ....., 191.....

JAN 18 1912

G. B. Crew

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 16, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1912, to Jan 16 1912, that I saw him alive on Jan 16 1912, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Acute ulceration

..... (Duration) ... yrs. ... mos. ½ ds.

CONTRIBUTORY (Secondary)

paralysis agitans (Duration) 1 yrs. ... mos. ... ds.

(Signed) Wm A B Sellman M. D.

Jan 17, 1912 (Address) 5 E Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem — DATE OF BURIAL, Jan 19, 1912

20-UNDERTAKER Geo M. Frick & Son — ADDRESS 811 W Lexington

Instructions on back of certificate.

Remarks No ptomaine poisoning. Acute indigestion due to something he had eaten. No chronic heart condition. No further history.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60390

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001
D 60390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1445 Hull St. WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Frederick Reidy.

(a) RESIDENCE. No. 1445 Hull ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew M Reidy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Violet Plasmeier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Violet Reidy.
(Address) 1445 Hull St.

15 Filed JAN 18 1922, 19 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1922 to Jan 17, 1922 that I last saw him alive on Jan 17, 1922 and that death occurred, on the date stated above, at 5.15A.m.

The CAUSE OF DEATH* was as follows:

Premature birth.
(7 mos.)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Shultz M. D.

(Address) 708 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mrs. J. E. Evans Sons	Jan 18 1922

20 UNDERTAKER Cedar Hill Cemetery ADDRESS 1428 Eutaw St.

241

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 60391
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 810 Wilkens ST. 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lenina Tyre

(Residence in Baltimore: No. 810 Wilkens St.; 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	Married

6-DATE OF BIRTH, Nov. 10, 1903
(Month) (Day) (Year)

7-AGE, 19 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Thomas
11-BIRTHPLACE OF FATHER (State or Country), Virginia
12-MAIDEN NAME OF MOTHER Sarah Jenkins
13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Helen I. Howard
(Address) Chapel Gate Lane

15-
Filed ....., 191.... H. W. Lim Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said jury
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy (Coroner.) M. D.
Jan. 16 1922 (Address) 2812 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Jan 18, 1922
20-UNDERTAKER Brown & Sheeler	ADDRESS 1404

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 60392

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 60392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~1707~~ 1107 E. Baltimore St., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Fleischman.

(a) RESIDENCE NO. ~~1407~~ 1407 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Fleischman.

6 DATE OF BIRTH (month, day, and year): Aug. 11, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: C. Fredrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Johanna D. Fleischman (Address) 1107 E. Baltimore St.

15 Filed JAN 18 1922 19 F. H. Klein Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1922 to Jan 16 1922

that I last saw her alive on Jan 14 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cancer Gallbladder

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm. J. Friedrich, M. D.

Jan 17 1922 (Address) 1025 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanuel Cem. DATE OF BURIAL: Jan. 18, 1922

20 UNDERTAKER: L. Hamm. ADDRESS: 32 S. Front.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Poplar Grove ST.) 15 WARD)

REGISTERED NO. 74 - 801 D 60393

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Sargable

(a) RESIDENCE. NO. 2203 Poplar Grove St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Conrad H. Buchholz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Dill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs A. Bohnstedt
(Address) 2001 Wilhelm St

15 FILED . 19 Registrar

N 1 81922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17/22

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1922, to Jan 17, 1922

that I last saw her alive on Jan 16, 1922

and that death occurred, on the date stated above, at 9:30a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. C. Adler, M. D.

1/17/22 (Address) 2757 Woods ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Calvary Cem Churchville Harford Co.	Jan. 19 1922

20 UNDERTAKER	ADDRESS
Josias Syfer	1600 W. Fayette

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA

(Westkamp)

D 60394

HEALTH DEPARTMENT--CITY OF BALTIMORE

1001

1871 D 60394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20 n Eden St.: 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Westkamp

(Residence in Baltimore: No. 20 n Eden St.: 50 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, March (Month) 3 (Day), 1862 (Year)

7-AGE, ~~70~~ 69 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fire patrolman
(b) General nature of industry, business, or establishment in which employed (or employer) 032

9-BIRTHPLACE, (State or Country), U.S.A.

PARENTS.

10-NAME OF FATHER, John H. Westkamp

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Annie Westkamp

(Address) 20 N. Eden st.

15-

JAN 18 1922

Filed ....., 191... J. H. Wehr Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Submersion

Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

1-17, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Jan 19, 1922

20-UNDERTAKER Jos. J. Kerr

ADDRESS 156 N. Luzerne ave.

in room

Accidental

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60395

D 60395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N Pulaski ST.: 20 WARD) 74-501

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Long

(a) RESIDENCE. NO. 8 N Pulaski ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theo N. Long

6 DATE OF BIRTH (month, day, and year) Nov 17 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Benj. Borg.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Ann M Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rev Theo Long (Address) Frost DC.

15 Filed JAN 18 1922, 19 J E Wilhm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1922 to Jan 17 1922

that I last saw h alive on Jan 17 1922

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? By symptoms

(Signed) A B Lemmon, M. D.

1/17, 1922 (Address) 718 N Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Jan 19 1922

20 UNDERTAKER George J Smith ADDRESS 1000 Lafayette st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST., 14 WARD)

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Maggie Smith

(a) RESIDENCE NO. Tylerton, Somerset Co. ST., ... WARD ...
(Usual place of abode) Md
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm T. Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework - 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Somerset Co Md.

PARENTS

10 NAME OF FATHER: Jno W. Bradshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tylerton Md

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tylerton Md

14 Informant: Miss Julia Smith.
(Address): 2723 W. North ave.

15 Filed JAN 19 1922, 19... Registrar: J. H. Wehn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1921, to Jan 18, 1922,

that I last saw her alive on Jan. 18, 1922,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cachexia Due to Carcinoma Head of pancreas - operated upon.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Operation (duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Dec. 21, 1921

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Leslie E. Wyatt, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tylerton Smith Island — DATE OF BURIAL: Jan 20 1922

20 UNDERTAKER: H. C. Branning & Son — ADDRESS: 1008 W. Fayette St.

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60397

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 N. North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick B. Miller

(a) RESIDENCE. No. 1637 N. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Sixteen yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie R. Miller

6 DATE OF BIRTH (month, day, and year): Mch. 30th 1859

7 AGE: Years 62 Months 6 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Auctioneer 086
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Hattie R Miller
(Address): 1687 N Broadway

15 Filed JAN 18 1922 19 J E Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15 1922, to Jan 17 1922
that I last saw him alive on Jan. 16 1922
and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mb Spilman M. D.

1-18, 19 23 (Address) 682 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew	Jany 19th 1922
20 UNDERTAKER	ADDRESS
David Sondheim	118 W Mt Royal Ave

TION is very important. See instructions on back of certificates.

If may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 60398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60398

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1415 Hobart ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos Oldham

(a) RESIDENCE NO. 1415 Hobart ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa C. Oldham

6 DATE OF BIRTH (month, day, and year) May 15-1836

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
85	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Drug

(c) Name of employer Gilpin Langdon & Co

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. M. Oldham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Susana Dugan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Edith Oldham (Address) 1415 Hobart St.

15 Filed JAN 18 1922, 19 ..... H.H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 15, 1922,

that I last saw him alive on Jan 15, 1922,

and that death occurred, on the date stated above, at 4 15/8 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arterio Sclerosis (Senile)

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Nitsch, M. D.

Jan 18, 1922 (Address) 2151 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan. 18 1922
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA... may be properly classified. ...in plain terms, so that it ma...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60399

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1172 W. Hamburg ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia M. Smoot

(a) RESIDENCE. No 1172 W Hamburg. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of— Charles L Smoot

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
11.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Patrick Donohoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Word

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Charles L Smoot

(Address) 1172 W Hamburg St.

15 Filed JAN 18 1922 19 H E Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17. 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1. 1922, to Jan 17, 1922, that I last saw h[illegible] alive on Jan. 15. 1922 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Last 6 mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A G Fruinger M. D.

1. 18. 1922 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 20. 1922
20 UNDERTAKER John F Conway & Son Per F J Conway	ADDRESS 921 Hollins St

TION is very important. See instructions on b[illegible] may be properly classified. Exact statement of OCCUPA- s on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60400

CERTIFICATE OF DEATH.

138 D 60400

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Calhoun ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Fragier

(Residence in Baltimore: No. 1113 N. Calhoun St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
fem.	col.	married

6-DATE OF BIRTH, Sept. 30, 1886
(Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic 037
(b) General nature of industry, business, or establishment in which employed (or employer): domestic

9-BIRTHPLACE, (State or Country), live in Balt 20 years Va.

PARENTS.

10-NAME OF FATHER, Jonah Tolson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Henrietta Smith

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Formsby (sister)

(Address) 426 Eastern Ave Baltimore Md.

15- JAN 18 1922

Filed ....., 191. J. H. Wehn Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 12 1922, to Jan. 17 1922, that I saw h.. alive on Jan. 16 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... yrs. ..... mos. 3 wks ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Thurmond M. D.

Jan. 17, 1922 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Jan 20, 1922
20-UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

Important. See instructions on back of certificate.

Remarks Phy. knows of no other abnormal condition

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D 60401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 60401

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Simpson Ct ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Williams

(a) RESIDENCE No. 1811 Simpson Ct ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62 years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country) Live in Baltimore 57 Years

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Ann Brown

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Carlos Williams
(Address) 134 Old York Road

15 Filed JAN 18 1922 19 Jeffelm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1921, to Jan 15th, 1922.

that I last saw h[illegible] alive on Jan 15, 1922;

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia Influenza Tuberculosis and Inflammation of Lungs Meningitis

(duration) — yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Acute Brights

(duration) 1 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Urinary Exam.

(Signed) Ged Hall M. D.

, 19 (Address) 1126 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 18 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Oakland Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

D 60402 HEALTH DEPARTMENT—CITY OF BALTIMORE 101

CERTIFICATE OF DEATH.

74 D 60402
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1027 Parish alley ST. 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucindia Bell

(Residence in Baltimore: No. 1027 Parish alley St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1842 (Year)

7-AGE, 80 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 041
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired Laundress)

9-BIRTHPLACE, (State or Country): Va.

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country),
12-MAIDEN NAME OF MOTHER
13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Bozeman
(Address) 1027 Parish alley

15-
Filed JAN 18 1922 191 S.E. Wehn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Heuisler M. D.
(Coroner.)
Jan 16, 1922 (Address) 502 Equitable Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pt. Richmond Cem
DATE OF BURIAL, Jan 15, 1922

20-UNDERTAKER Geo. L. Dennis
ADDRESS 1313 Druid

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

✓ Dr Kolb 1203 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60403

CERTIFICATE OF DEATH.

118-0 D 60403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Arlington Sanatorium ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine B. Davenport

(a) RESIDENCE NO. 3310 Gwyn Oak Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) deceased

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Noah Brall

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha A Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George H. Brall
(Address) 3310 Gwyn Oak Ave

15 Filed JAN 18 1922 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 22, 19 Jan 17, 1922, that I last saw h[illegible] alive on Jan 17th 1922, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Bloll, M. D.

Jan 17th 22 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	1/19 1922
20 UNDERTAKER William Cook	ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60404

D 60404

CERTIFICATE OF DEATH.

46

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 431 East Lynn St. (or) 20 (WARD)

2-FULL NAME Catherine E Duchesney

(a) RESIDENCE NO. 431 East Lynn St. WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson L Duchesney

6 DATE OF BIRTH (month, day, and year) Sept 23 1877

7 AGE: Years 44 Months 3 Days 24 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Prince George County Md

PARENTS

10 NAME OF FATHER: John Pennington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Margaret E Mechlaffer 431 East Lynn St

15 Filed JAN 18 1922 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to Jan 16, 1922, that I last saw h[illegible] alive on Jan 15, 1922, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Toxic vomiting, pros. [illegible] Contributory (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 20-21

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Fernada W. McNally M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 19 1922

20 UNDERTAKER: William Cook — ADDRESS: 526 E Natl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 60405

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 421 E. Fort Ave. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda C. Smith

(a) RESIDENCE. No. 421 E. Fort Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Smith

6 DATE OF BIRTH (month, day, and year) July 7 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co. Md.

PARENTS

10 NAME OF FATHER Walter M. March

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co. Md.

12 MAIDEN NAME OF MOTHER Elsie Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Ralph C. Percy
(Address) 421 E. Fort Ave.

15 Date received JAN 18 1922

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1922 to Jan 17 1922.

That I last saw her alive on Jan 17 1922.

and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Embolism 0032
Entirely bedridden in chair 4 hours
(duration) yrs. mos. ds.
CONTRIBUTORY (secondary) Fecal Impaction
(duration) thirty One week yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry B Noll M. D.

(Address) 1703 Light

Jan 18 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk Cem	1/19 1922
20 UNDERTAKER	ADDRESS
I. Frew McCully	130 E. Fort

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No chr. endocarditis
Fecal impaction probably
had something to do
with embolism.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60406

100-001 D 60406

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3711 Fernwood Av ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Phelan

(a) RESIDENCE NO. 3711 Fernwood Av ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Brigid Phelan

6 DATE OF BIRTH (month, day, and year) March 7-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Martin Phelan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Dugan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Brigid Hughes (Sister)

(Address) 203 S. Fifth St.

15 Filed JAN 18 1922, 19 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1921, to Jan 16, 1922

that I last saw him alive on Jan 15, 1922

and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. McAvoy, M. D.

Jan 18 1922 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Jan. 19 1922
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60407

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2438 Foster Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick O'Bryan

(a) RESIDENCE NO. 2438 Foster Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann O'Bryan

6 DATE OF BIRTH (month, day, and year) March 15-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William O'Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mary Ann O'Bryan

(Address) 2438 Foster Ave

15 Filed . 19 Robert F. Harrison, Burial Permit Clerk. Registrar

8-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 8 . 1921 . to Jany 17 . 1922.

that I last saw him alive on Jany 16 . 1922.

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cobler V Pilley M. D.

(Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cath Lawn Cem

DATE OF BURIAL Jan. 20 1922

20 UNDERTAKER Lilly & Zeiler

ADDRESS 1038 Mad Ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Dobyns)

Form — 6-9-19 — H. P. Co. — 1000 ftks.

D 60408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60408

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Md. Gen Hosp't ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Dobyns

(a) RESIDENCE. NO. 2707 Parkwood Ave. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Allen Dobyns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma B Shockey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm A Dobyns (Address) 2707 Parkwood Ave

15 Filed JAN 7 1922, 19 .. A. Registrar J E Wehr

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17th 1922

17

I HEREBY CERTIFY, That I attended deceased from 12/27/21 19 . to 1/17/22 19 .

that I last saw h alive on 1/17/22 19 .

and that death occurred, on the date stated above, at 9:35 m.

The CAUSE OF DEATH* was as follows:

Cerebral meningitis

(duration) . yrs. mos. ds.

CONTRIBUTORY (Secondary) Typhoid

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of 1/7/22

Was there an autopsy? —

What test confirmed diagnosis? Clynical

(Signed) J A Dougherty, M. D.

. 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan 20th 22
20 UNDERTAKER	ADDRESS
Bertram Lorte	1723 N Howard St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 60409 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60409

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Appleton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Isabel Peters

(a) RESIDENCE. NO. 1729 Appleton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas L. Peters

6 DATE OF BIRTH (month, day, and year) 12-19-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER J. Mantles

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Ann Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) C. Peters 1729 E Appleton St

15 Filed JAN 18 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to January 17, 1922

that I last saw her alive on Jan 16 1922, 19

and that death occurred, on the date stated above, at 8.12 a. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. One mos. 17 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death? At place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heat & Nitric acid test for albumen & Fehling test for sugar

(Signed) Charles E. Clark M. D.

Jan 17, 1922 (Address) 1306 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenslager DATE OF BURIAL Jan. 20 1922

20 UNDERTAKER Martin Funkhouser ADDRESS 1827 N North Ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60410

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Albemarle ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pawel Trzypowski

(a) RESIDENCE. No. 30 albemarle ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40	—		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) nopow

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER nopow

11 BIRTHPLACE OF FATHER (city or town) (State or country) nopow

12 MAIDEN NAME OF MOTHER nopow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) nopow

14 Informant Adom Urbus

(Address) 30th Albemarle St.

15 Filed Robert P. Harrison, Registrar

JAN 18 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1922.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1920 to Jan. 17 1922

that I last saw him alive on Jan. 16 1922

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ? yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) John a Buchness, M. D.

, 19 (Address) 650 Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislowas	Jan 19 1922
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 s Paca St.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 D 60411

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1015 E Lombard ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John O'Brien

(Residence in Baltimore: No. 1015 E Lombard St

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word.) Married

6-DATE OF BIRTH, Unknown, 1
(Month) (Day) (Year)

7-AGE. About 50 yrs. mos. da.

If LESS than 1 day, brs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eastern Tube Plateau

(Address) Bond St Near Broadway

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

181922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest at
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest at
(Inquest, autopsy or inquiry.) find that said deceased came to h— death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) Thomas J. Ryan Coroner M. D.

Jan 16, 1922 (Address) 1800 N. Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem

DATE OF BURIAL, Jan 18, 1922

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

IMPORTANT.—CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60412

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 N. Charles ST.: 23 WARD)

2-FULL NAME baby Wilburn

(a) RESIDENCE. NO..... ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17. 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER William Wilburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Virginia Filetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant
(Address)

15 Filed ..... 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

8 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,
that I last saw h... alive on ....., 19...,
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Compression of brain
due to Dystocia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) E. L. Marr M. D.

1. 18. 1922 (Address) 801 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 18 1922
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	733 Wagner St

TION is very important. See instructions on back of ... be properly classified. Exact statement of OCCUPA- ... ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60413

CERTIFICATE OF DEATH.

101-001 D 60413

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S. Calvaton Road WARD 10)

2-FULL NAME. Kate Bonhoff

(a) RESIDENCE. NO. 114 S. Calvaton Rd. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. H. Bonhoff

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Martin Hittel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Franz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. H. Bonhoff

(Address) 114 S. Calvaton Road

15 Filed ..... 19.. Robert P. Harris Registrar

AN 1 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1922, to Jan. 15, 1922, that I last saw h[illegible] alive on Jan. 15, 1922, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. F. Mara, M. D.

1/17 1922 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mon Cathedral	Jan. 19 1922
20 UNDERTAKER	ADDRESS
Geo. L. Schwab	101 Dudley Ave.

IT IS IMPORTANT that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60414

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 D 60414

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE (No. 4802 Delaware Ave 27 Ward) Arlington
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Bowersock

(Residence in Baltimore: No. 4802 Delaware Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7-AGE. About 60 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. James F. Quinn

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Annie E. McCormick

13-BIRTHPLACE OF MOTHER. (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nettie V Chapman
(Address) Carleigh Heights Md

15-
Filed 1 8 1922 192
Robert F. Harrison,
Burial Permit Clerk. Registrar.

Dr Mooney Roland Ave

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Gas Poison
Carbon Monoxide
accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) John Mooney M. D.
(Coroner)
(Date) 1922 (Address) 502 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park
DATE OF BURIAL. 1 19 1922

20-UNDERTAKER. William Cook
ADDRESS 502 E North

If very important. See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—5-19-13—M. & T.—500 Bks.

D 60415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60415

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 5012 Beauregard Av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anne J. C. Helder

(Residence in Baltimore: No. Same 5012 Beauregard ave St.; ...yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. December 21, 1890 (Month) (Day) (Year)

7-AGE. 31 yrs. 1 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Allentown, Pa.

PARENTS.

10-NAME OF FATHER. Griffith P. Edell

11-BIRTHPLACE OF FATHER (State or Country). Lehigh Co, Pa

12-MAIDEN NAME OF MOTHER Hannah Leibenguth

13-BIRTHPLACE OF MOTHER (State or Country), Lehigh Co. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. W. Helder

(Address) 5012 Beauregard ave.

15- Robert P. Harrison,

Filed ..... 1922 Burial Permit Clerk.

84922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 25 1921, to January 18 1922, that I saw her alive on January 18 1922, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) ....yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary)

Pneumonia (Duration) ....yrs. .... mos. 2 ds.

(Signed) Geo. H. Bresler M. D.

Jan 18, 1922. (Address) 521 Sheridan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 4 mos. ds. In the State yrs. 4 mos. ds.

Where was disease contracted, if not at place of death? Allentown, Pa

Former or usual residence Allentown, Pa

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Allentown Pa	Jan. 20, 1922
20-UNDERTAKER Wm Cook	ADDRESS 502 E. North Ave.

IMPORTANT. See instructions on back of certificate.

D 60416

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

14-001

D 60416

REGISTERED No. C .....

1 PLACE OF DEATH (See letter attached)

CITY OF BALTIMORE (No. 1445 Towson St. WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Katie Jackewitz

(Residence in Baltimore: No. 1445 Towson St.: 42 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Jan 11 1842 Dec. 1837 (Month) (Day) (Year)

7 AGE: 80 yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. Kackowsky

(Address) 1445 Towson St

15 Robert P. Harrison, Reg. , 191

REGISTRAR Burial Permit Clerk.

1 81922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: (Month) Jan. (Day) 17, (Year) 1922

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1922, to Jan 17 1922.

that I saw h alive on Jan 16, 1922.

and that death occurred, on the date stated above, at 4 PM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(Duration) .... yrs. .... mos. 5 ds

Contributory (SECONDARY)

(Duration) .... yrs. .... mos. .... ds.

(Signed), Thos F. Stevens M. D.

Jan. 18, 1922 (Address) 2878 Hartford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross Cem. Md. DATE OF BURIAL: Jan 19 1922

20 UNDERTAKER: Stephen Falkowski ADDRESS: 1000 N Kenwood Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer* or *Planter*, *Phy*, *Civ*, case, sary, the, an, it sl, *Spi*, (*a*) worl, Nev, "De, *Day*, Wor, hous, defin, *work*, ploy, to re, in dc, *maid*, up o, cupa, ness, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be

asles (disease
a (secondary),
terminal con-
erely sympto-
Convulsions,"
), "Dropsy,"
rrhage," "In-
," "Uræmia,"
can be ascer-
seases result-
ERPERAL *sep-*
State cause
rtaken. For
nd qualify as
robably such,
mples: *Acci-*
— accident;
oned by car-
of the injury,
e. g., *sepsis*,
f "Contribu-

nal informa-
tion which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

DR. THOMAS F. A. STEVENS
2878 HARFORD ROAD COR. HUGO AVENUE
BALTIMORE, MD.
OFFICE HOURS 8 TO 9 A M 7 TO 8 P M
PHONE HOMEWOOD 4221 REG. NO 5015

DATE
Name
Address

R
Dr. C. Hampson Jones.
Communicate to Health.
Balto Md.

Scarlatina Family change 27 Oct
Certificate No. 60416 Jones
84 years. 1 month 15 days To
80 years. 6 days.
Jan 23 1923. Thos F A Stevens M D

WM. MORGENSTERN
PHARMACIST
COR HULL ST AND FORT AVE
BALTIMORE MD

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60417

CERTIFICATE OF DEATH.

D 60417

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecile O'Donnell

(a) RESIDENCE No. Greenville, S.C. ST., WARD Greenville S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 3rd 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: John O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Pet. Carlton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant: Mrs. Jno. O'Donnell
(Address) 1431 N. Broadway

15 Filed 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/18/1922

17 I HEREBY CERTIFY, That I attended deceased from 10/21, 1921, to 1/18, 1922,
that I last saw h alive on 1/18, 1922,
and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

OVER

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion due to vomiting following Operation

(duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/26/21.

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings.

(Signed) H. B. Lucas M. D.

1/18, 1922 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenville, S.C.	2-18-1922
20 UNDERTAKER	ADDRESS
J. A. Moran	3 and E Baltimore

DEATH is very important. See instructions on back of certificates.

which had undergone extensive ... gall bladder which was thickened & Gall bladder removed no improvement continuous vomiting, Gastro enterostomy, continuous vomiting. Death. Note from the above this victim apparently died of chr. appendicitis with adhesions according to surgical opinion & not of peritonitis caused by surgical operation

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This patient was case of continuous vomiting. Two operations were performed for adhesions without relief. She gradually lost strength until she had a cardiac break & terminal edema. No other cause than above stated can be given as cause of death.

H. K. Neale.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60418

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001
100

D 60418

CERTIFICATE OF DEATH.

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Bouldin ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Davis

(a) RESIDENCE. No. 107 S Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 20 1918

7 AGE — Years: — Months: 3 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER Samuel Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Lou Mann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant Samuel Davis
(Address) ~~1073 Baldwin~~

15 Jan 17 1922 . 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 1922 to 17 Jan 1922.

that I last saw him alive on 17 Jan 1922.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Rales, Temp + Resp

(Signed) [illegible] M. D.

. 19 (Address) 3015 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orange Va.

DATE OF BURIAL: 2 19 1922

20 UNDERTAKER: J. F. Moran

ADDRESS 2000 E Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60419

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Florence Fowler

(a) RESIDENCE. No. 2306 E. Biddle ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 29 1885

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	36		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 170

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Joseph Dyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Annie Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mercy Hospital Record. (Address)

15 Filed Jan 19 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1921, to Jan 17, 1922, that I last saw her alive on Jan. 17, 1922, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cachexia.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Sept. 1921

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Examination

(Signed) John A. Fogarty, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	2-20-1922
20 UNDERTAKER J. G. Moran	ADDRESS 3 car E. Baltimore

TION is very important. See instructions on back of certificates.

...at it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60420

CERTIFICATE OF DEATH.

31

D 60420

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2857 Woodbrook St.; 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm F. Loose Jr.

(a) RESIDENCE. No. 2857 Woodbrook St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Elsie N. Loose

6 DATE OF BIRTH (month, day, and year) April 12, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm F. Loose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER — Hamp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Elsie N. Loose. (Address) 2857 Woodbrook.

15 Filed 1 8 1922 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 17. Jan. 1922

17 I HEREBY CERTIFY, That I attended deceased from May. 1 - 1921. to Jan 17 1922.

that I last saw h~~im~~ alive on Jan. 17 1922.

and that death occurred, on the date stated above, at 6. a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At 2857 Woodbrook ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X Ray & Sputum

(Signed) J. Thomas Jobson, M. D.

. 19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 19 1922

20 UNDERTAKER: Harry K. Wetzel — ADDRESS: 1531 W. Fayette

IMPORTANT. See instructions on back of certificates.

Frances Steward

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓001

D 60421

CERTIFICATE OF DEATH.

14 D 60421

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 13 Broadway Court ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Steward

(a) RESIDENCE. No. 13 Broadway Court ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Steward

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 0/6

(b) General nature of industry, business, or establishment in which employed (or employer) Washing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Steward

(Address) 13 Broadway Court

15 Filed JAN 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17th, 1922, to Jan 17th, 1922, that I last saw her alive on Dec " ", 19 ", and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L. Winsor, M. D.

1-28, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Jan 19 1922
20 UNDERTAKER John W Henderson	ADDRESS 1502 E. Monument

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60422

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1100 (St.) Brentwood Ave (WARD) 101

2-FULL NAME Alfred B. Elliott

(a) RESIDENCE NO. 1100 Brentwood St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Chesterton Md

PARENTS

10 NAME OF FATHER Thomas B. Elliott

11 BIRTHPLACE OF FATHER (City or town) (State or country) Chestertown Md

12 MAIDEN NAME OF MOTHER Mary Baker

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Chestertown Md

14 Informant Elma E. Vogt

(Address) 5 Elwood Ave Hamilton

15 Filed JAN 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-1922

17 I HEREBY CERTIFY, That I attended deceased from January 7th, 1922, to January 18th, 1922, that I last saw him alive on January 18th, 1922, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Collateral Edema

Meningitis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard E. Woodey, M. D.

1/18/1922 (Address) 530 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	1/20 1922
20 UNDERTAKER	ADDRESS
Mullikin Corse	526 North

IMPORTANT.—Certificates should be filled out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60423

CERTIFICATE OF DEATH.

161 D 60423

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Feinstein

(a) RESIDENCE NO. 2032 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	0

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Jan 18, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 20 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Louis Feinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Sklar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Johns Hopkins Hospital Beach

15 Filed JAN 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1922. to Jan 18, 1922.

that I last saw her alive on Jan 18, 1922

and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

{ Asphyxia Pallida
{ Intra cranial Hemorrhage

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) H. Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Knen circle Cem	Jan 18 1922

20 UNDERTAKER — ADDRESS

Jack Levis 1411 E Balto St

TION is very important See instructions on back of certificates. | Exact statement of OCCUPA- | that it may be properly classified. | on plain terms, so that it

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60424

CERTIFICATE OF DEATH.

129 D 60424

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Schroeder St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mimetta E. Marker

(a) RESIDENCE. No. 411 N. Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. [redacted] Marker

6 DATE OF BIRTH (month, day, and year): [redacted] 859

7 AGE: Years 63 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 1900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: John A Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Anna L Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Md.

14 Informant: Mrs. Chesnut

(Address) 411 N. Schroeder

15 Filed JAN 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18½ 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 '21, 1921, to Jan 18, 1922, that I last saw h.. alive on Jan 17, 1922, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray, M. D.

(Address) 5510 N. Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 20 1922

20 UNDERTAKER: Robert L. Little — ADDRESS: 270 Edmondson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60425

CERTIFICATE OF DEATH

D 60425

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Dijon Hill ST.: 75 WARD) 1708 Washington Ave 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W Imealy

(Residence in Baltimore: No. 1 Dijon Hill St.: 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: 7 (Month) 5 (Day), 1852 (Year)

7-AGE: 69 yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer): 038

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: J. G. Imealy

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Sarah J Clark

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. A. Imealy

(Address) 3501 Fairview Ave

15-

Filed....., 191.....

Registrar.

JAN 19 1922

ROBERT R. KRAUTER
Deputy Register of Wills

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: 1 (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1921, to Jan 17 1922, that I saw him alive on Jan 17 1922, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatism followed by Senile Regurgitation, Bright's Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 10 ds.

(Signed) C. H. Bellstein M. D.

1 18, 1922 (Address) 700 Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, Jany 21 1922

20-UNDERTAKER John Ottitebell ADDRESS 120 W. Fayette St

IMPORTANT: See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

May Scherf

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60426

CERTIFICATE OF DEATH.

1/29 D 60426

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Church Home & Inf. ST., 17 WARD)

2-FULL NAME Mrs. May Scherf.

(a) RESIDENCE NO. 2223 Homewood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick O. Scherf.

6 DATE OF BIRTH (month, day, and year): May 27-1881

7 AGE: Years 40 Months 7 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, md

PARENTS

10 NAME OF FATHER: Jacob D. Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Mary Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: F. O. Scherf
(Address): 2223 Homewood Ave

15 Filed JAN 19 1922 ..... Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June, 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/30/, 1921, to 1/17/, 1922,
that I last saw h.er alive on 1/17/, 1922,
and that death occurred, on the date stated above, at 5:15 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Insufficiency.
Chronic Nephritis.
Pulmonary Congestion.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): pulmonary congestion.
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) P. D. Noble, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Jany. 20 1922

20 UNDERTAKER: John Oursler — ADDRESS: 120 N. Fayette

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Gioshon

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60427

CERTIFICATE OF DEATH.

90 D 60427

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Greshon

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City, New York.

PARENTS

10 NAME OF FATHER E. Walter Greshon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick, Maryland

12 MAIDEN NAME OF MOTHER Louise Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JAN 19 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from December 1, 1921 to January 16 1922.
that I last saw her alive on January 16, 1922.
and that death occurred, on the date stated above, at 9:00 P.M.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (uration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Lot Brumbrek, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Jany. 20 1922

20 UNDERTAKER ADDRESS

John O. Mitchell 120 N. Fayette St.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See over)

D 60428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 60428

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1032 E. 29th — ST. 17th WARD) Anne Elizabeth Chew White Jan 21-1922

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Elizabeth Chew White

(a) RESIDENCE NO. 1032 E. 29 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Captain John C. White

6 DATE OF BIRTH (month, day, and year): Dec 13. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md

PARENTS

10 NAME OF FATHER: Judge T. J. C. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Cora Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Nash Co Md

14 Informant: T. J. C. Williams

(Address): 1032 E. 29 St—

15 Filed JAN 19 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1921, to Jan 18, 1922.

that I last saw h[illegible] alive on Jan 18, 1922

and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) [illegible] M. D.

1/19, 1922 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lappans Nash. Co Md	Jany 20th 22.
UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DR. N. E. B. IGLEHART
1008 CATHEDRAL STREET
BALTIMORE, MD.

To the Health Department -
Baltimore City. Md -

This is to certify that Anna E.C. White widow of Capt John C. White, is the same person as Anna Williams White - for whom I issued the certificate of the death of Anna E. C. White at 1 A.M. Jan 18/22

Jan 23/22 N. E. B. Iglehart

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.
(Approved by U. S. Census and American Public Health Asso.)

port "typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of

Spec.—1-10-21—M&T—1500 Blks.

D 60429 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60429

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Compton ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy J Schaefer

(a) RESIDENCE No. 904 Compton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 12 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William A Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mary E Schaefer 904 Compton St

15 Filed JAN 19 1922, 19 J E Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Jan 18, 1922, that I last saw living alive on Jan 17, 1922, and that death occurred, on the date stated above, at 9 15 a m.

The CAUSE OF DEATH* was as follows:

Acute Brights. 20d

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. E. Smith, M. D.

Jan 19 1922 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A A Co Md — DATE OF BURIAL: Jan 21 1922

20 UNDERTAKER: John F Dennis. — ADDRESS: 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Smith knows of no other abnormal condition

Spec.—1-10-21—M&T—1500 Bks.

D 60430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 60430

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Retreat ST., 13 WARD)

2-FULL NAME J. Franklin Nelker

(a) RESIDENCE NO. 1526 Retreat ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year): Mar. 28 1876

7 AGE: Years 45 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Architect

(b) General nature of industry, business, or establishment in which employed (or employer): 586

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: A. Henry Nelker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Edard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Horace J. Nelker

(Address) 1526 Retreat St

15 Filed JAN 24 1922 19 S E Kehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3 1922, to Jan. 16 1922, that I last saw him alive on Jan. 16th 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Nephritis; Uraemia and gastric Hemorrhage

(duration) 1 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine Ex. Blood Press ek

(Signed) S. A. Dodds, M. D.

Jan 17 1922 (Address) 3101 Clifton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem DATE OF BURIAL: Jan 24 22

20 UNDERTAKER: Wm Fickus & Sons ADDRESS: Norfolk Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60431

CERTIFICATE OF DEATH.

1929 D 60431

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 932 N Gilmor ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Laydon Davies

(a) RESIDENCE NO. 932 N Gilmor ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary P. Davies

6 DATE OF BIRTH (month, day, and year) May 25 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 209

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Adams Express Co

9 BIRTHPLACE (city or town) (State or country) Accomac Co Va.

PARENTS

10 NAME OF FATHER Landon N Davies

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sue Todd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Norris S Russell
(Address) 114 Melrose Ave.

15 Filed ..., 19... [illegible] 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1922, to Jan 18 1922, that I last saw him alive on Jan 18 1922, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion
Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pneumonic Conn

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 185 E 1st St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlestown Md. DATE OF BURIAL Jan 20 1922

20 UNDERTAKER Wm J Luckie & Sons ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Hammerlacher
835 Eight St
Chronic Interstitial
Nephritis

Spec.—1-10-21 M&T 1500 Blks.

D 60432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 60432

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 E 25th ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August E. Blom.

(a) RESIDENCE NO. 1732 E 25 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Margaret A Bateman

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	10	27	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Steam Boat Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Government

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10 NAME OF FATHER Gustav Blom.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway.

12 MAIDEN NAME OF MOTHER Petra Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Margaret A Blom. (Address) 1732 E 25th St

15 Filed JAN 19 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921 to June 18, 1922.

that I last saw h... alive on June 17, 1922

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Pulmonary Oedema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of ?

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Chas Bowers, M. D.

Jun 19 22 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va.	1/24/ 1922

20 UNDERTAKER E J Fanning & Son ADDRESS 1938 E Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60433

CERTIFICATE OF DEATH.

25 - 90

D 60433

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20 N. First St. Brooklyn. St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Purnell Reynolds.

(Residence in Baltimore: No. 20 N. First St. Brooklyn.

65 St.; yrs., 3 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, October 9th. 1856., 1 (Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Joseph Reynolds.

11-BIRTHPLACE OF FATHER (State or Country). Howard Co. Md.

12-MAIDEN NAME OF MOTHER Elizabeth A. Redden.

13-BIRTHPLACE OF MOTHER (State or Country). Pocomoke, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachael Reynolds. (wife)

(Address) 20 N. First St. Brooklyn.

15- Filed JAN 19 1922 191.... ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17th. 1922., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. E. Reynolds M. D. (Coroner.)

Jany 17th 1922 (Address) 10 17 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Jan 19th., 1922

20-UNDERTAKER Joseph D Cook ADDRESS 1003 N. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60434

D 60434

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1721 W. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Simpson

(Residence in Baltimore: No. 1721 W. Lanvale St.; 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) Jan. (Day) 7, (Year) 1835

7-AGE, ... 87 yrs. ..... mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At home
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, P. W. Smick

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna B. Simpson

(Address) 2337 Edmondson Ave

15- JAN 1 9 1922 ROBERT R. KRAUTER,
Filed ....., 191.....
Burial Permit C... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January (Month) 18 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1922, to Jan. 18 1922, that I saw her alive on Jan. 18 1922, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

..... Arteriosclerosis .....

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

..... (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Howard A. Kelly M. D.

Jan. 18, 1922 (Address) 735 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Jan 21., 1922

20-UNDERTAKER Fickler & Fickler E.T.D.

ADDRESS 1739 Eager

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60435

CERTIFICATE OF DEATH.

100-001

D 60435

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1117 N. Stricker ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Daly

(Residence in Baltimore: No. 1117 N. Stricker St.: yrs., 3 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH. Oct. 23, 1921
(Month) (Day) (Year)

7-AGE. ....yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None 800
(b) General nature of industry, business, or establishment in which employed (or employer). Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Daily Kean

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ida Daly

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Daly

(Address) 1117 N Stricker St.

15-

Filed JAN 19 1922 191 ROBERT R. KRAUS Chief Clerk.
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 15, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

Jan 16, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	....., 19....
20-UNDERTAKER	ADDRESS
Commissioner Health.	JAN 1 . 1922

JOHNS HOPKINS HOSPITAL

8820

important. See instructions on back of certificate.

properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60436

CERTIFICATE OF DEATH.

D 60436

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 S. Eblinton st ST.; 26 WARD)

REGISTERED NO. C 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Arnett

(Residence in Baltimore: No. 123 S. Eblinton St. St.; 61 yrs., 11 mos. 17 ds.)

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very property. Underlined.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan. 30th (Month) (Day), 1860 (Year)

7-AGE, 61 yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at Home D

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Schriefer.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Barbara Fleischman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Buckenstein

(Address) 123 S. Eblinton St

15-

Filed 1 9 1922, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 14th 1922, to Jany 17th 1922, that I saw her alive on Jany 17th 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (~~Secondary~~)

(Duration) ....yrs. ....mos. ....ds.

(Signed) David W. Jones M. D.

1/19/, 1922 (Address) 1011 E. Ellwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Jan 20, 1922

20-UNDERTAKER Lilly Zeiler

ADDRESS 1035 S. Hoyt St

D 60437 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D 60437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE (No. 1 ST., WARD) REGISTERED No. C

2-FULL NAME Minnie A Meyer. (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1031 N Caroline St. St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month) 13 (Day) 1867 (Year)

7-AGE, 54 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Agent. German
(b) General nature of industry, business, or establishment in which employed (or employer) Society of Nd.

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. J. D. Meyer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Fredericka Wentzel

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Charles H. Meyer

(Address) 1031 N. Carolina St

15- Robert P. Harrison.

Filed ..., 191... Registrar.

1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Atheroma

(Duration) yrs. mos. ds.

(Signed) G. C. Yoder M. D.

(Coroner)

Jan 19 22 (Address) 143 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Lauden Park Cem. DATE OF BURIAL, Jan 20, 1922

20-UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St

...may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Sonn)

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 60438

CERTIFICATE OF DEATH.

A 100-601 B 60438

15-2-83

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard A. Sonn

(a) RESIDENCE. No. Fullerton Balto. Co. Md ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 months yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick W. Sonn

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsie Graves

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant F. William Sonn Jr
(Address) Fullerton Md.

15 Filed . 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29th, 1921, to Jan. 17th, 1922, that I last saw h alive on Jan. 17th, 1922, and that death occurred, on the date stated above, at 3:20 a m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

OTW

(duration) yrs. mos. 15 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In hospital

Did an operation precede death? Yes Date of Dec 30-21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Jan. 20 1922
20 UNDERTAKER	ADDRESS
Fredk Lovell Sons	Fullerton Md.

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic) "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for epilepsy.
Not known No further
history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60439

CERTIFICATE OF DEATH.

X 74-001

D 60439

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob J. Dieter (Dieter)

(a) RESIDENCE (No.) Fullerton Road (St.) (Ward.) Fullerton Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Dieter

6 DATE OF BIRTH (month, day, and year): July 16th 1842

7 AGE — Years: 79. Months: 6 Days: —

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer): Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jack. J. Dieter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. Anna Dieter Fullerton Md.

15 Filed 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1922

17 I HEREBY CERTIFY, That I attended deceased from January 3 1922 to Jan 16 1922

that I last saw him alive on Jan 16 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Mumma, M. D.

19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Cemetery	Jan 20 1922
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Sons	Fullerton

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60440 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60440

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2048 Bank ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Keenan

(a) RESIDENCE. No. 219 S Chester ST., 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Keenan

6 DATE OF BIRTH (month, day, and year) July 22-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Ins + Int. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Thos Keenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Elizabeth Keenan
(Address) 219 S Chester St

15 Robert P. Harrison,
Registrar

1 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1918, to Jan 18, 1922, that I last saw him alive on Jan 18, 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + physical signs

(Signed) A. F. Bendrich, M. D.

, 19 (Address) 5 E. Pattison Pl. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	1-20-1922
20 UNDERTAKER J. A. Moran	ADDRESS 320 E Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60441

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 60441

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Duckett,

(a) RESIDENCE NO. Preston Valley St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 80. Unknown				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Clarke Co. Md.

PARENTS

10 NAME OF FATHER Josiah Duckett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence -
(Address) Preston & Valley Sts.

15 Filed Jan 19 1922 Robert F. Harney
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 18 1922

17 I HEREBY CERTIFY, That I attended deceased from February 19 to , 19 ,
that I last saw h[illegible] alive on Jany 15 , 1922,
and that death occurred, on the date stated above, at 7.20 a. m.
The CAUSE OF DEATH* was as follows:

Arteria sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Warner, M. D.

Jany 18, 1922 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter	Jan 21st 1922
20 UNDERTAKER Joseph A Farrell	ADDRESS 1319 Division

TION is very important. See instructions on back of certificates.

W NORTH

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60442

CERTIFICATE OF DEATH.

46

D 60442

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 N Durham ST. WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathilda Harmon

(a) RESIDENCE NO. 37 N Durham st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Harmon

6 DATE OF BIRTH (month, day, and year): about know 1870

7 AGE: Years 51 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto, md.

PARENTS

10 NAME OF FATHER: Geo. Tholmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Andrew Harmon

(Address) 37 N. Durham St

15 Filed 1/19 1922 Robert F. Barrabee, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7 1921 to Jan 17 1922

that I last saw h alive on Jan 15 1922

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. G. Tolson M. D.

1/17 1922 (Address) 6772 Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan. 19 1922

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E NORTH

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back

D 60443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2606 E. Baltimore ST.: 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F Leeds

(Residence in Baltimore: No. 2606 E. Baltimore, St. 65 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Nov 24, 1847 1857

7-AGE, 74 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER: Edward W Leeds.

11-BIRTHPLACE OF FATHER (State or Country), Eng.

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lavinia Leeds

(Address) 2606 E Balto St

15-

(Date) Jan 19 1922 Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism by Glass cut

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) M J Mulloy M. D.
(Coroner)

1-18, 1922 (Address) 7 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, 1-20, 1922

20-UNDERTAKER Wm Cook — ADDRESS 502 E. North Ave

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 1 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60444 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60444

CERTIFICATE OF DEATH. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs J. Agnes Grace

(a) RESIDENCE. No. Mt Hope Retreat ST., 28th WARD. Washington D C

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9mo	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER James Grace

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Burke

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 [illegible] 19 Registrar

1 91922

Robert F. Maybach, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19. 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3rd, 1919, to June 19, 1922, that I last saw her alive on June 19, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Scabies (Complicated by Partial Gangrene of Lower R. Limb) at least (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr Melancholia at least (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington DC

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	1/19/22
20 UNDERTAKER	ADDRESS
Chas F. Ware & Son	1180 W Mt Royal ave

TION is very important. See instructions on back of certificates.

if may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

001

101 D 60445

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 226 S Washington ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kurek

(a) RESIDENCE. NO. 226 S Washington ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Kurek

6 DATE OF BIRTH (month, day, and year) Oct 16 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER George Kurek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Wanhaken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Frances Kurek
(Address) 226 S Washington

15 Filed Jan 19 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1922 to Jan 18 1922, that I last saw him alive on Jan 18 1922, and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Hosty (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Kolb, M. D.

Jan 19 1922 (Address) 1302 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 21 1922

20 UNDERTAKER John McAleer ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 15 DAY December

OF 1964 THE MICROPHOTOGRAPHS APPEARING

HEREIN STARTING WITH #D57256- Sept. 27, 1921 AND

ENDING WITH #D-60445 JAN. 19, 1922 ARE AC-

CURATE AND COMPLETE REPRODUCTIONS OF THE

RECORDS OF THE DEPARTMENT OF Health

BUREAU OF Vital Statistics AS DELIVERED

IN THE REGULAR COURSE OF BUSINESS FOR

PHOTOGRAPHING, AND THAT:

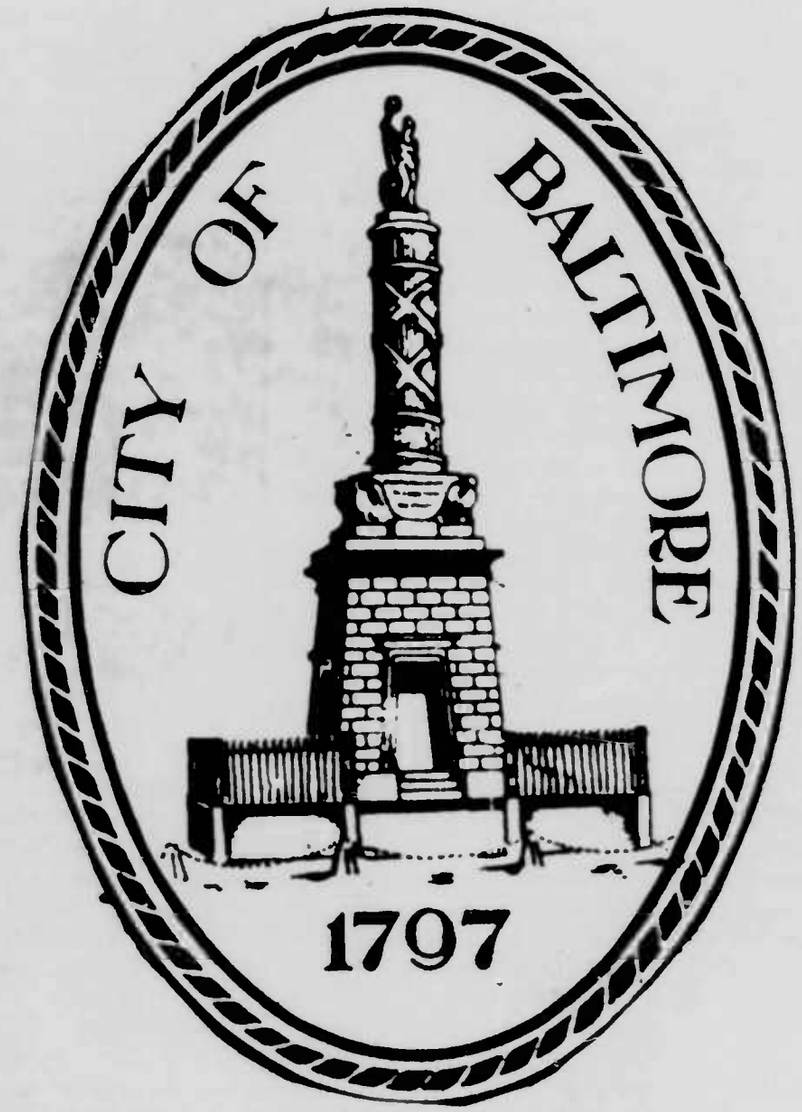
TO THE BEST OF MY KNOWLEDGE THE MICROFILM

MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU

OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC

COPY.

CAMERA OPERATOR: D. McFaul



END OF REEL